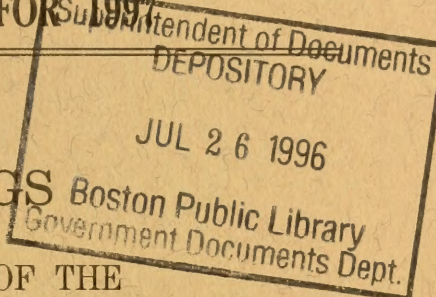


DEPARTMENTS OF LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION, AND RELATED AGENCIES
APPROPRIATIONS FOR 1997

Y 4. AP 6/1:L 11/997/PT. 2

Departments of Labor, Health and Hu...



BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTH CONGRESS
SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

JOHN EDWARD PORTER, Illinois, *Chairman*

C. W. BILL YOUNG, Florida
HENRY BONILLA, Texas
ERNEST J. ISTOOK, JR., Oklahoma
DAN MILLER, Florida
JAY DICKEY, Arkansas
FRANK RIGGS, California
ROGER F. WICKER, Mississippi

DAVID R. OBEY, Wisconsin
LOUIS STOKES, Ohio
STENY H. HOYER, Maryland
NANCY PELOSI, California
NITA M. LOWEY, New York

NOTE: Under Committee Rules, Mr. Livingston, as Chairman of the Full Committee, and Mr. Obey, as Ranking
Minority Member of the Full Committee, are authorized to sit as Members of all Subcommittees.

S. ANTHONY McCANN, ROBERT L. KNISELY, SUSAN E. QUANTIUS, MICHAEL K. MYERS,
and JOANNE L. ORNDORFF, *Subcommittee Staff*

PART 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	Page
Secretary of Health and Human Services	1
Health Care Financing Administration	157
Administration for Children and Families	387
Administration on Aging	891
Special Tables	991

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 1997

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

JOHN EDWARD PORTER, Illinois, *Chairman*

C. W. BILL YOUNG, Florida

HENRY BONILLA, Texas

ERNEST J. ISTOOK, JR., Oklahoma

DAN MILLER, Florida

JAY DICKEY, Arkansas

FRANK RIGGS, California

ROGER F. WICKER, Mississippi

DAVID R. OBEY, Wisconsin

LOUIS STOKES, Ohio

STENY H. HOYER, Maryland

NANCY PELOSI, California

NITA M. LOWEY, New York

NOTE: Under Committee Rules, Mr. Livingston, as Chairman of the Full Committee, and Mr. Obey, as Ranking Minority Member of the Full Committee, are authorized to sit as Members of all Subcommittees.

S. ANTHONY MCCANN, ROBERT L. KNISELY, SUSAN E. QUANTIUS, MICHAEL K. MYERS,
and JOANNE L. ORNDORFF, *Subcommittee Staff*

PART 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	Page
Secretary of Health and Human Services	1
Health Care Financing Administration	157
Administration for Children and Families	387
Administration on Aging	891
Special Tables	991

Printed for the use of the Committee on Appropriations

U.S. GOVERNMENT PRINTING OFFICE

24-954 O

WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402

ISBN 0-16-052784-8

COMMITTEE ON APPROPRIATIONS

BOB LIVINGSTON, Louisiana, *Chairman*

JOSEPH M. MCDADE, Pennsylvania
JOHN T. MYERS, Indiana
C. W. BILL YOUNG, Florida
RALPH REGULA, Ohio
JERRY LEWIS, California
JOHN EDWARD PORTER, Illinois
HAROLD ROGERS, Kentucky
JOE SKEEN, New Mexico
FRANK R. WOLF, Virginia
TOM DELAY, Texas
JIM KOLBE, Arizona
BARBARA F. VUCANOVICH, Nevada
JIM LIGHTFOOT, Iowa
RON PACKARD, California
SONNY CALLAHAN, Alabama
JAMES T. WALSH, New York
CHARLES H. TAYLOR, North Carolina
DAVID L. HOBSON, Ohio
ERNEST J. ISTOOK, JR., Oklahoma
HENRY BONILLA, Texas
JOE KNOLLENBERG, Michigan
DAN MILLER, Florida
JAY DICKEY, Arkansas
JACK KINGSTON, Georgia
FRANK RIGGS, California
MIKE PARKER, Mississippi
RODNEY P. FRELINGHUYSEN, New Jersey
ROGER F. WICKER, Mississippi
MICHAEL P. FORBES, New York
GEORGE R. NETHERCUTT, JR., Washington
JIM BUNN, Oregon
MARK W. NEUMANN, Wisconsin

DAVID R. OBEY, Wisconsin
SIDNEY R. YATES, Illinois
LOUIS STOKES, Ohio
TOM BEVILL, Alabama
JOHN P. MURTHA, Pennsylvania
CHARLES WILSON, Texas
NORMAN D. DICKS, Washington
MARTIN OLAV SABO, Minnesota
JULIAN C. DIXON, California
VIC FAZIO, California
W. G. (BILL) HEFNER, North Carolina
STENY H. HOYER, Maryland
RICHARD J. DURBIN, Illinois
RONALD D. COLEMAN, Texas
ALAN B. MOLLOHAN, West Virginia
JIM CHAPMAN, Texas
MARCY KAPTUR, Ohio
DAVID E. SKAGGS, Colorado
NANCY PELOSI, California
PETER J. VISCLOSKEY, Indiana
THOMAS M. FOGLIETTA, Pennsylvania
ESTEBAN EDWARD TORRES, California
NITA M. LOWEY, New York
RAY THORNTON, Arkansas
JOSE E. SERRANO, New York

JAMES W. DYER, *Clerk and Staff Director*

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RE- LATED AGENCIES APPROPRIATIONS FOR 1997

THURSDAY, APRIL 18, 1996.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

WITNESS

HON. DONNA E. SHALALA, U.S. SECRETARY OF HEALTH AND HUMAN
SERVICES

INTRODUCTION OF WITNESS

Mr. PORTER. The subcommittee will come to order.

This morning we have the first of our hearings with our three cabinet secretaries, and, Secretary Shalala, we are pleased to welcome you this morning to kick off what will be two weeks of hearings on your Department's 1997 budget request. We recognize that it is a challenging circumstance for all of us to consider 1997 funding without having reached final agreement on the 1996 program levels, but the imperatives of our calendar require us to begin the 1997 cycle, and, hopefully, the 1996 bill will be resolved by the time we have your Department complete its testimony here.

We also would like to thank you for providing us with the justifications on time.

I call on Mr. Hoyer for any comments he would like to make.

Mr. HOYER. Thank you very much, Mr. Chairman.

I certainly want to welcome the Secretary to this hearing. I think you rightfully observed that I chuckled. It is a real challenge for the agencies that have not been funded for 1996 to then begin 1997 not being assured of what the base line is or what the parameters are.

Mr. Chairman, I want to congratulate the Secretary. I think she has done an outstanding job, and I think one of the President's best choices for Cabinet Secretary was Secretary Shalala, and I look forward to her testimony and to this hearing.

Thank you, Mr. Chairman.

Mr. PORTER. Thank you, Mr. Hoyer.

Secretary Shalala, you may proceed any way you would like.

OPENING STATEMENT

Secretary SHALALA. Thank you very much, Mr. Chairman, and thank you, Congressman Hoyer.

Thank you for giving me the opportunity to discuss the President's 1997 budget for the Department. Our budget builds upon the progress in the last three years as deficit reductions and targeted investments in health science continue to pay off for the American people.

Today childhood immunization rates are at the highest levels in history, and vaccine preventable childhood diseases are at an all time low. Child poverty is down and child support collections are up.

Since March of 1994 welfare case loads have declined by more than 1.4 million, and a larger percentage of those still on welfare are engaged in work-related activities.

In fact, Mr. Chairman, 75 percent of all of the people on welfare in this country are now in programs that are under waivers.

Our investments in biomedical research have helped lead to the discovery of three genes linked to hereditary breast cancer, the approval of five new antiviral drugs for people living with HIV-AIDS, and the first treatment for the most common form of stroke.

The President's proposed budget for 1997 builds on this success. It requests a total of \$222 billion in spending for programs that fall under the jurisdiction of this subcommittee. Of this amount, discretionary spending totals \$31 billion, an increase of five percent over the 1996 policy level.

We believe that we can balance the budget in seven years, ensure fiscal accountability and reform Welfare, Medicare and Medicaid, while still protecting our nation's fundamental priorities and values, and that's what the President's fiscal year 1997 budget does.

For those trying to move to independence, the President's budget for welfare makes changes that encourage work, demand responsibility and protect children. We do this by replacing the current Aid to Families with Dependent Children program with a new conditional entitlement in which assistance is provided only in return for work and preparation for work.

Overall, our proposal would save \$40 billion over seven years, while still protecting vulnerable children.

The President's budget also reforms Medicaid the right way. It saves \$59 billion over seven years, it maintains a strong Federal-state partnership while giving states unprecedented flexibility to meet the needs of their citizens, it retains nursing home quality standards, it maintains Medicaid's national guarantee of health care for our most vulnerable citizens.

The President's Medicare plan reduces the growth of projected spending by \$124 billion over seven years and guarantees the solvency of the hospital insurance trust fund for more than a decade. We are making our Medicare life line more efficient and responsive to our citizens by giving seniors more choices among private health plans, cracking down on health care fraud and abuse and cutting the growth of provider payments while still holding Part B premiums at 25 percent of program costs.

To meet our citizens' health care needs we must also guarantee quality and fiscal accountability, and that is exactly what we are doing. In fiscal year 1995 our Inspector General, the Health Care Financing Administration and the Administration on Aging teamed

up with officials in five key states to crack down on health care fraud and abuse. It is called Operation Restore Trust, and we want to expand it to every state over the next three years.

Our fiscal year 1997 budget calls for \$597 million to give HCFA and the Office of the Inspector General the secure and stable financing that they need not only to punish health care fraud and abuse, but also to stop it before it occurs.

Mr. Chairman, we are changing the way we do business at HHS not only in Medicare, Medicaid and welfare, but throughout the Department. As part of the President's plan to dramatically shrink the size of the Federal Government, we reduced our staff by nearly 3,300 FTE, a full five percent, between fiscal year 1994 and fiscal year 1995 alone. And, to meet the President's goals, we have committed ourselves to a seven-year right-sizing effort that will reduce the Department's personnel by 7,000 FTE by the year 2000.

To streamline our Department we have merged some of our operations and eliminated entire management levels. We have merged the operations of the Assistant Secretary for Management and Budget with the Assistant Secretary for Personnel Management, thereby eliminating one assistant secretary slot, and we freed the Assistant Secretary for Health from day-to-day management responsibilities in order to strengthen the absolutely critical leadership and policy role in the Department's public health and science agenda. We have also created an innovative agency, a program support center, whose sole purpose is to provide administrative services on a fee-for-service basis for HHS and other Federal agencies.

Under the leadership of Lynnda Regan, a former business manager at Westinghouse, the PSC will be internally financed, competitive and create real incentives for long-term savings. It is truly a model built for the future, and it is all part of a fundamental commitment to business-like management throughout the Department.

Let me take a moment to tell a story that I think best exemplifies the kind of vision and tough-minded management approach that we brought to the Department in the past three years:

It is a story of Head Start, Congressman Hoyer, a program that when done right, works superbly to give our most vulnerable children a hand up on the educational ladder and a hand up in life. But as we found out when we got here, and as you pointed out to us, in some communities Head Start wasn't always being done right. So we brought in the best experts in the country and asked them for a candid assessment of what needed to be improved, and then we rolled up our sleeves and got right down to work. With those experts and a bipartisan effort in Congress, we developed ways to set quality standards that provided resources to help centers meet them and to enforce strict penalties for those who don't.

Since 1993 we have helped 100 grantees improve their programs and provide quality services to their children, but that is only half of the story. We have also gotten tough by cracking down and ultimately shutting down those programs that aren't meeting quality standards. In just two and a half years, some 40 programs have been terminated before they have really received their grants.

Mr. Chairman, while we work to implement smart, tough management throughout the Department, we have continued our com-

mitment to investing in the future health and well-being of all Americans. From day one, Head Start and our overall commitment to our neediest children has been a top priority to this Administration. For fiscal year 1997 we have proposed an increase of \$350 million to serve 46,000 more children than we served in 1995. As part of this enrollment increase, an additional 7,400 infants and toddlers will be able to participate in the early Head Start program between fiscal year 1995 and 1997.

The President believes strongly that the best safety net for our children is, and always will be, strong families, and whether parents are struggling to get jobs or to keep them, we know that they need good child care to keep their children safe. And, that is why we are requesting over \$1 billion for the child care block grant so that more children of low income families can have high quality child care, and their parents can have peace of mind while they work, train or go to school.

We have all heard the horror stories of abused children, neglected children, forgotten children. The President wants to work with states and communities to stop these tragedies, and that is why he is requesting \$419 million in discretionary spending to help abused and neglected children by encouraging parental responsibility when possible and providing foster care and adoption when necessary.

Our commitment to children doesn't stop there. The President believes that we must help parents guide their children along the right path, the healthy path, the safe path in life. That means increasing our investment in AIDS prevention by \$34 million. It means building on the President's historic child tobacco initiative by supporting innovative community partnerships that give children the facts about a deadly addiction that could take years off their lives. It means working with the White House Drug Policy Coordinator, General Barry McCaffrey, to ensure that engines of our drug strategy—prevention, treatment, research, interdiction and law enforcement—are working together.

When it comes to preventing teen pregnancy, it means building on our success from targeted demonstration grants to Welfare waivers that require teen mothers to stay in school and live with a responsible adult.

To ensure a clear message of abstinence and responsibility while addressing the broader health needs of young people, our budget also includes a new \$30 million initiative. This effort helps communities all over America implement local strategies with promising track records of reducing teen pregnancy.

Next, our fiscal year 1997 budget continues to put fighting disease and foster good health at the top of our priority list where they belong. To that end, we have requested \$310 million to turn the 40-year old Warren G. Magnuson Clinical Center at the National Institutes of Health into a state-of-the-art clinical research center and hospital. This investment in a new clinical center will mean the highest quality clinical research performed by the world's very best scientists in a research hospital that is more efficient, more affordable and more flexible in adapting to today's realities and tomorrow's challenges.

Our budget also provides \$6.6 billion to NIH to fund a record total of 25,400 extramural research grants. Our commitment to research has already brought some real successes in the fight against AIDS, but this fight is a long way from being won and that is why the President has requested a consolidated appropriation of \$1.4 billion, nearly 34 percent over the 1993 levels, for the Office of AIDS Research so that we can ensure a flexible and coordinated response to the epidemic.

Today new and emerging infectious diseases are a reality that threaten all of us in our water, in our air and in our food. The President's budget almost doubles the \$45 million for our investment in the Centers for Disease Control and Prevention's national strategy for identifying, investigating and ultimately stopping new infectious diseases around the world.

We also request \$4 million to renovate and repair critical containment laboratory space at the CDC in Atlanta, laboratories that are this nation's first line of defense against these deadly diseases.

Mr. Chairman, these investments pay off not only in dollars and cents, but most importantly in healthier lives and brighter futures, and that is what our 1997 budget is all about. It is about balancing the budget, it's about being tough managers and making a sustained investment in the preventive tools all of our citizens from the youngest to the oldest will need to thrive in the 21st century.

We look forward to working with this subcommittee in our fiscal year 1997 budget request.

Thank you again for giving me the opportunity to present our budget to the subcommittee, and I would be happy to answer any questions that you may have.

[The prepared statement of Secretary Shalala follows:]



THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

**Testimony of
Donna E. Shalala
U.S. Secretary of Health and Human Services**

**before
The House Appropriations Subcommittee on
Labor, Health and Human Services, Education and
Related Agencies**

April 18, 1996

Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to discuss President Clinton's FY 1997 Budget for the Department of Health and Human Services.

This budget is built on a remarkably strong foundation of accomplishments that have resulted from carefully chosen investments in the health and independence of all Americans. Time and time again these investments have paid off.

For example, childhood immunization rates have reached an all-time high and the incidence of childhood infectious diseases is declining.

Welfare case loads are down by more than 1.4 million, a decrease of 10 percent, since March 1994; child poverty is down and child support enforcement collections are up.

Our investments in biomedical research have helped lead to the discovery of three genes linked to hereditary breast cancer.

We have also witnessed the first drug treatment for severe sickle cell anemia and the first treatment for the most common form of stroke.

And our investment in medicine has helped scientists win approval for five new anti-viral drugs for people living with HIV/AIDS, including three very promising protease inhibitors, two of which were approved in record time.

We have already granted waivers to 37 states that are now reforming welfare for 10 million parents and their children - that's about 70 percent of all AFDC recipients.

With this strong foundation in mind, we have designed a budget to help Americans help themselves in pursuing more healthy and independent lives.

This FY 1997 budget requests a total of \$222 billion in spending for programs that fall under the jurisdiction of this Subcommittee. Of this request, discretionary spending totals \$31 billion, which is an increase of 5 percent over the FY 1996 policy level. [The FY 1996 policy level is based on levels of the ninth continuing resolution, including an incremental policy adjustment.]

The President believes that we can balance the budget in seven years, ensure fiscal accountability, reform welfare, and strengthen and improve Medicare and Medicaid.

Our budget for FY 1997 helps us do just that.

The President's Medicare plan reduces the growth of projected spending by a net \$124 billion over seven years, and guarantees the solvency of the Hospital Insurance Trust Fund for more than a decade. We are reforming Medicare to make it more efficient and responsive to beneficiary needs, to give seniors more choices among private health plans, to attack fraud and abuse, to cut the growth of provider payments, and to hold the Part B premium to 25 percent of program costs.

The President's budget also reforms Medicaid the right way: it maintains a strong federal-state partnership, while giving states unprecedented flexibility to meet the needs of their citizens. The plan would save \$59 billion over seven years while retaining nursing home quality standards, and maintaining Medicaid's national guarantee of health care for our most vulnerable citizens.

We also have a tough plan to guarantee program integrity and fiscal accountability in the Medicare and Medicaid programs.

In FY 1995, the HHS Inspector General (OIG), Health Care Financing Administration (HCFA), and the Administration on Aging teamed up with officials in five key states to crack down on health care fraud and abuse. This program is called Operation Restore Trust. We want to expand this program to every state over three years.

Our FY 1997 budget calls for an expenditure of \$597 million to give HCFA and the OIG the secure and stable funding they need not only to punish health care fraud and abuse, but also to stop it before it occurs. Our budget would increase spending to eliminate fraud, waste and abuse with expected net savings to the trust funds of \$3.4 over seven years.

Our budget also includes President Clinton's comprehensive welfare reform plan that promotes work and responsibility and achieves \$40 billion in program savings. The President's plan would replace the AFDC program with a conditional entitlement with tough time limits and work requirements, while retaining a strong national safety net for children.

Mr. Chairman, we're changing the way we do business at HHS - not only in Medicare, Medicaid and welfare but throughout the Department.

As part of the President's plan to dramatically shrink the size of the federal government, we reduced our staff by nearly 3,300 FTE, a full 5 percent, between FY 1994 and FY 1995 alone. To meet the goals of the President's plan, we have committed ourselves to a seven-year right-sizing effort that will reduce the Department's personnel by 7,000 FTE (from the FY 1993 level) by the year 2000.

In March 1995, we successfully launched the Social Security Administration (SSA) as an independent agency, thanks to the careful planning of both HHS and SSA staff.

Based on this change and on the implementation of the Vice President's Reinventing Government program, we have streamlined the structure of our Department. We merged some of our operations and eliminated entire management layers - we have freed the Assistant Secretary for Health from day-to-day management responsibilities in order to strengthen this absolutely critical leadership and policy role in the Department's public health and science agenda.

We also have merged the operations of the Assistant Secretary for Management and Budget with the Assistant Secretary for Personnel Management. The final result of these reorganizations is a lean, tightly organized Office of the Secretary.

We also have created an innovative new agency, the Program Support Center (PSC), whose sole purpose is to provide administrative services on a fee-for-service basis for HHS and other federal agencies. This agency is internally financed and competitive, and it is offering its services on a low-cost fee-for-service basis. Fees and service levels will be approved by a Board consisting of representatives of both customers and service providers.

After a nationwide search, I have just appointed Lynnda Regan as the first Director of the PSC. Ms. Regan is a highly respected executive from Westinghouse and brings to the Department valuable private sector knowledge and experience. With Ms. Regan's leadership and the management structure we have created, the PSC is really a model built for the future. It represents our fundamental commitment to business-like management throughout the Department.

Mr. Chairman, perhaps most important, our FY 1997 budget continues its wise investment in the future health and well-being of all Americans.

Today's young people are tomorrow's leaders. Thus, we are committed to the goal of building Strong Foundations and providing Safe Passages for all children and youth. Strong Foundations are the building blocks of success for children and families, while Safe Passages provide some of the tools for navigating the often turbulent journey from childhood to young adulthood.

One such Strong Foundation is our Head Start program. Head Start is a program that, when done right, works to give children who are most at-risk a hand up on the educational ladder and a hand up in life.

Let me take a moment to tell a story about Head Start that I think best exemplifies the kind of vision and tough-minded management approach that we've brought to this department during the past three years.

At the beginning of our Administration, we discovered that in some communities, Head Start wasn't always being done right.

So, we brought in the best experts in the country - and asked them for a candid assessment of what needed to be improved. And then, we rolled up our sleeves and got right down to work. With those experts and bipartisan support in Congress, we set quality standards, provided resources to help centers meet these standards, and enforced strict penalties for those who fail.

Since 1993, we've helped 100 grantees improve their programs and provide quality services to their children.

Our philosophy concerning Head Start is that we reward and demand quality from all of our programs. For those that can't, or won't meet these demands, we will have closed and close or reform their programs. Indeed, since October 1993, approximately 40 grantees have been terminated or have relinquished their grants for failure to meet quality standards.

For FY 1997, we have proposed an increase of \$447 million over the FY 1995 level to serve 46,000 more children than we served in FY 1995. As part of this enrollment increase, between FY 1995 and FY 1997 an additional 7,400 infants and toddlers will be able to participate in the Early Head Start program.

The President believes strongly that the best safety net for our children is - and will always be - strong families. And, whether they're struggling to get jobs or keep them, we know that families need good child care to keep their children safe.

That's why the President is requesting over \$1 billion for the Child Care block grant - so that more children from low-income families can have high quality child care and their parents can have peace of mind while they work, train or go to school.

We've all heard the horror stories: abused children; neglected children; forgotten children. The President wants to work with states and communities to stop these tragedies. That's why he's requesting \$419 million in discretionary spending to help abused and neglected children - by encouraging parental responsibility when possible and providing foster care and adoption when necessary.

Our commitment to children doesn't stop there. The President believes that we must help parents guide their children along the right path - the healthy path - the safe path - in life.

That means increasing our investment in AIDS prevention by \$34 million. It means building on the President's historic children's tobacco initiative by supporting innovative community partnerships that give children the facts about a deadly addiction that could take years off their lives.

It means working with the White House Drug Policy Coordinator, General Barry McCaffrey, to ensure that all engines of our drug strategy - prevention, treatment, research, interdiction and law enforcement - are working together.

And, when it comes to preventing teen pregnancy, it means building on our success, from targeted demonstration grants to welfare waivers that require teen mothers to stay in school and live with a responsible adult.

To help ensure a clear message of abstinence and responsibility, while simultaneously addressing the broader health, social, education and employment needs of young people, our budget includes a new \$30 million initiative that will help communities all over America implement local strategies with promising track records of reducing teen pregnancy.

A second key component of our FY 1997 budget is to maintain cutting edge health and science programs. To that end, we have requested \$310 million for a revitalized Warren G. Magnuson Clinical Center at the National Institutes of Health (N I H).

This new state-of-the-art clinical center will house nearly half of all clinical research beds in the country and provide new and promising research opportunities for intramural and extramural scientists.

Our budget also provides \$6.6 billion to NIH to fund a record total of 25,400 extramural research grants. With regard to AIDS research, we request a separate appropriation of \$1.4 billion, nearly 34 percent over 1993 levels, which the Office of AIDS Research will direct to the most promising areas of scientific inquiry.

We also must be on guard against new and emerging infectious diseases that threaten all of us - in our water, in our air, and in our food. Therefore, the President's budget almost increases to \$88 million CDC's national research, surveillance and prevention efforts against such diseases in 30 states. We also request \$4 million to renovate and repair critical containment laboratory space at the Centers for Disease Control and Prevention in Atlanta - laboratories that are the first line of defense against these deadly diseases.

Further highlights of our FY 1997 budget are as follows:

- Health Resources and Services Administration (HRSA) - The FY 1997 budget request for HRSA is \$3.1 billion. A total of \$807 million is proposed for Ryan White activities, a \$32 million, or 4 percent increase over the FY 1996 level. This will continue our commitment to improve the quality and availability of care for individuals and families with HIV and AIDS. The request for the Consolidated Health Centers cluster provides \$757 million for grants to local health centers that serve vulnerable underserved populations, including migrant workers, homeless individuals, and residents of public housing. This funding level maintains our commitment to ensure that they receive quality health care. In keeping with the Department's strong commitment to investing in programs that support Strong Foundations and Safe Passages for our Nation's children, the HRSA budget supports funding for several programs with the sole mission of improving the health of women of childbearing age and their children. These programs include the Maternal and Child Health Block Grant (\$681 million); Healthy Start (\$75 million); and the Title X Family Planning program (\$198 million).
- Centers for Disease Control and Prevention (CDC) - The FY 1997 request for CDC provides a \$2.3 billion level of spending. Of that amount, \$488 million will be spent on CDC discretionary programs for childhood immunization to continue increasing the percentage of two-year-olds fully immunized, which has increased from 55 percent in 1992 to 75 percent in 1995. These funds, when combined with the Vaccines for Children (VCF) entitlement program, bring the total HHS childhood immunization expenditures to approximately \$1 billion. A total of \$617 million, an increase of \$34 million (6 percent) over FY 1996, is requested for CDC's HIV/AIDS prevention programs. The request includes \$20 million for applied HIV/AIDS research to identify effective interventions for specific populations.
- National Institutes of Health (NIH) - The FY 1997 request for NIH totals \$12.4 billion, an increase of \$467 million, or 4 percent, over the FY 1996 level. This includes an additional \$274 million for facility construction and renovation, primarily for the Warren G. Magnuson Clinical Research Center and an additional \$193 million for research activities. NIH has constructed its budget request to minimize the impact on research project grants of this onetime extraordinary facilities cost. An additional \$99 million is requested for FY 1997 to emphasize research on the biology of brain disorders; on new approaches to pathogenesis, the study of disease origins and development; on new preventive strategies against disease; on genetics of medicine; and on advanced instrumentation and computers in medicine and research. The highest research priority of NIH is the support of basic biomedical research through investigator-initiated research project

grants (RPGs). These grants support new and promising ideas cutting across all areas of biomedical research. In FY 1997, the NIH budget provides \$6.6 billion to support a record total of 25,400 RPGs, including 6,827 new and competing RPGs. The FY 1997 budget request continues to include all of NIH's AIDS-related funds-\$1.4 billion-in a single account for the Office of AIDS Research (OAR), as these funds were appropriated in FY 1995. The Director of OAR will transfer AIDS funds to the Institutes in accordance with the comprehensive plan for AIDS research developed by the OAR along with the Institutes. The Administration strongly supports a consolidated AIDS appropriation as a vital part of ensuring a coordinated and flexible response to the AIDS epidemic.

- Substance Abuse and Mental Health Services Administration (SAMHSA) - The budget request for SAMHSA totals \$2.1 billion. This request will provide important substance abuse and mental health services to thousands of pregnant women and their children, high risk youth, and other underserved Americans. This budget request for FY 1997 focuses on the treatment of chronic substance abusers who are responsible for most of the crime related to drugs and for the use of 75 percent of all illegal drugs brought into this country. An increase of \$244 million is requested to treat and prevent mental illness and substance abuse, and therefore, addressing recent trends in these areas. Also proposed is \$1.5 billion for both the Substance Abuse and Mental Health Performance Partnership state grants that give states maximum flexibility to develop treatment systems that ensure access, quality, and improved outcomes for substance abusers, particularly in areas of high incidence and prevalence of substance abuse.
- Agency for Health Care Policy and Research (AHCPR) - The FY 1997 request for AHCPR provides a program level of \$144 million. Consistent with a Department-wide HHS Survey Integration Plan, AHCPR will fully fund the Medical Expenditure Panel Survey (MEPS)-replacing the National Medical Expenditure Survey (NMES)-at \$45 million, as well as continue to fund its highest priority ongoing research commitments, the Research on Health Care Outcomes and Quality program at \$48 million, and the Health Care Systems Cost and Access program at \$48 million.
- Health Care Financing Administration - HCFA is the largest purchaser of health care in the world. In FY 1997 Medicare and Medicaid expenditures will be about \$319 billion for 72 million beneficiaries. The FY 1997 request for HCFA program management is \$2.2 billion. Of this request, 73 percent will go to 77 private sector insurance companies throughout the United States who pay for the care given to Medicare beneficiaries. Only about 16 percent (i.e., \$359 million) of the requested amount will go to fund federal employees and activities (about one tenth of 1 percent of total projected Medicare and Medicaid outlays). These activities will maintain and strengthen the Department's commitment to develop more efficient

operating systems; manage programs to fight fraud, waste and abuse; and promote and monitor managed care spending and quality of care. To deal with the level of growth in the number of health care facilities, an additional \$28 million is included in the request for the Survey and Certification program.

- Administration for Children and Families (ACF) - ACF is the Department's lead agency for programs serving America's children, youth, and families. For FY 1997, we are seeking \$7.7 billion for discretionary programs that promote healthy children, supportive families, and vibrant communities. Investing in Head Start and expanding enrollment are key Presidential priorities. The FY 1997 budget request of \$3.98 billion for Head Start will serve an additional 46,000 children, establishing strong foundations for a total of nearly 800,000 children and their families. The budget request for the Child Care and Development Block Grant is \$1.049 billion. This request is a component of the Administration's continued commitment to promoting family self-sufficiency by helping states fund child care services for more children from low-income working families. ACF is requesting \$419 million for a range of discretionary programs that help states and local communities to protect children by strengthening families and preventing abuse; intervening when families are in crisis; and when necessary, making placement decisions to ensure children's safety. To address a serious social problem for our nation, teen pregnancy, the Department will launch a \$30 million Teen Pregnancy Prevention Initiative in FY 1997. These funds will be used to implement and evaluate promising prevention strategies in communities that have demonstrated a commitment to community problem solving. This effort is an important step forward to ensure safe passages for our Nation's adolescents.
- Administration on Aging (AoA) - The FY 1997 budget for AoA provides \$828 million for programs aimed at improving older Americans' quality of life. For FY 1997, AoA requests \$451.2 million for Nutrition Programs, designed to continue providing the 240 million congregate and home-delivered meals served to needy senior citizens. This request also includes \$295 million to provide funding for a network of 57 state units, 670 Area Agencies on Aging, approximately 6,000 senior centers and more than 27,000 service providers, and \$16 million for 215 Indian tribal organizations throughout the country. A total of \$9.2 million is requested for in-home services for the frail elderly. The Long-Term Ombudsman Program will be funded at \$4.5 million and will serve 1.5 million nursing home residents. To improve service and to streamline administration, the request provides for the transfer of USDA's Nutrition Program for the Elderly (NPE) and the Department of Labor's Senior Community Services Employment Program (SCSEP) to AoA.

- Departmental Management (DM) - The DM budget includes requests for three separate appropriations-General Departmental Management (\$145 million), Office for Civil Rights (\$22 million), and Policy Research (\$9 million)-that fund activities to provide leadership, policy, legal, and administrative guidance to HHS components; carry out the Department's civil rights and nondiscrimination enforcement programs; and support research to develop policy initiatives and improve existing HHS programs.
- Office of Inspector General (OIG) - The OIG requests \$75 million, an increase of \$1 million above the FY 1996 level. OIG will focus its resources in the following areas: reviewing our efforts to improve children's welfare and child support enforcement collection initiatives; evaluating providers and services in the Medicare and Medicaid programs; ensuring the effectiveness of the public health delivery programs; auditing management control systems and financial operations; and the final phase of Operation Restore Trust. The Medicare Anti-fraud and Abuse Program (MAAP) is a proposed initiative to restore trust and accountability to the Medicare program. This initiative would build on the proven effective aspects of Operation Restore Trust, enhance general Medicare fraud protection activities, allow the OIG to pursue innovative antifraud initiatives, enhance data systems to assess trends and identify possible fraud and abuse, and expand OIG resources by retraining and adding staff to those parts of the country where fraud schemes are unfolding. Should this legislation be enacted, an additional \$54 million in mandatory funding will be added to supplement OIG's current effort.

In summary, Mr. Chairman, we present a FY 1997 budget that:

- builds on and maintains the President's commitment to balance the budget in seven years;
- adheres to the goals of the Vice President's National Performance Review by "right-sizing" our management structure and developing new business approaches to delivering administrative services in a low-cost, efficient manner;
- provides critical social and health services to vulnerable children and families;
- maintains our national commitment to cutting-edge health and science programs.

Our FY 1997 budget represents a strong, well thought out, and fiscally prudent blueprint to guide us into the 21st century. It's about balancing the budget, being tough managers, and making a sustained investment in the health and human service programs that all of our citizens-from the youngest to the oldest-will need to thrive in the 21 st century.

We look forward to working with this Subcommittee on our FY 1997 budget requests. Thank you again, Mr. Chairman, for the opportunity to present our budget to the Subcommittee. I will be happy to answer your questions.

Mr. PORTER. Thank you, Madam Secretary.

Before we begin with questions, I want to call on the ranking member of our subcommittee and the ranking member of the Full Appropriations Committee, Mr. Obey, for any statement that he might want to make.

Mr. OBEY. I have none.

OUTYEAR PROJECTIONS

Mr. PORTER. All right.

Madam Secretary, let me applaud your statement. I think it reflects the kind of management that you bring to your job, which is of the highest quality, and I might say that clearing the decks on Head Start programs, for example, that aren't really Head Start programs or really doing the job for kids is exactly the kind of message that resonates very well with our side of the aisle. And we applaud you for looking into those programs, reviewing them and terminating those that really don't perform.

As I said a moment ago to you, personally, I believe that what the Congress is doing and what the Administration is doing is reflecting what is happening out there across America, and that is we are tightening up our standards in every way, better management, better use of funds, more accountability, looking for results from the money that we spend. And I think that is your approach to the management of your Department, and that is, believe me, all to the good.

I want to talk about the President's budget just a bit because I'm concerned that while it indicates a balance over the seven years, the Congressional Budget Office tells us that some of the cuts in the out years—particularly the late out years—are simply unlikely ever to be able to be enacted even if they would be realistic.

What I would like to ask, first, then is what about the out years of discretionary spending for HHS? What does that look like? Are there continual increases or what does the President suggest here?

Secretary SHALALA. Well, I think that the President will protect his major investments, and we expect some increases in those investments. That includes the National Institutes of Health, Head Start and a handful of investments that he has identified. We will be expected to either slow down the growth, either flat line or actually cut other parts of the discretionary budget. It will not be easy. Of course, all of these depend on what the estimates are at the time. I see the budget as a whole. We fully expect to be able to slow down the growth of Medicare and Medicaid, and change the way in which we are doing Welfare programs. We expect those parts of the budget also to show genuine savings as we begin to slow down that growth. We are, as you know, going to be enthusiastically and firmly going after waste, fraud and abuse in Medicare and Medicaid, in particular with a new initiative and demonstration called Operation Restore Trust.

Mr. PORTER. Well, if I read you correctly, you're saying we're going to slow down the growth of Medicare and Medicaid, but yet the President has firmly rejected the approach that the Congress has suggested in doing that, and to my knowledge has not come back with any approach of his own.

Does that simply mean that we are going to cut reimbursements and have it somehow absorbed out there? What kind of proposal should we look for?

Secretary SHALALA. The President has submitted a proposal, first, in his balanced budget and then reflected in this 1997 budget that slows down the growth of payments to providers. What it does do, which is different than what your party has suggested, is it protects beneficiaries. It also increases the number of choices for Medicare beneficiaries. It provides tremendous flexibility for the governors to move Medicaid recipients to managed care without prior waiver approaches, and it has as part of that an expansion of Operation Restore Trust, which firmly, for the first time, gives us a real handle on going after fraud and abuse in both of the major entitlement programs.

Mr. PORTER. Well, I think we have spent the last 16 months or so rejecting each other's approaches on these kinds of issues that every one of us realizes has to be addressed. There will be no discretionary budget at all unless we address the rate of increase in the entitlement programs, particularly Medicare and Medicaid, and I would hope that we might see in the next couple of weeks as this last Continuing Resolution runs out a real effort on behalf of the Administration and the Congress to find common ground on last year's budget and to resolve our differences and get on with governing the country. Obviously, we don't see things perfectly eye to eye, but I think we are a lot closer than the media would suggest to the American people, and I think we can find common ground, and I sincerely hope that we can begin that process by having agreement on the 1996 spending levels and get our job done.

Mr. Obey.

Mr. OBEY. Thank you, Mr. Chairman.

First of all, let me simply say that I appreciate very much what you and your Department have done to try to see to it that the promises that both political parties are making on the issue of welfare are something other than baffled gab. I hope that you keep it up. I really find it amusing and amazing that some people can promise that we are going to move people off welfare into the real world of work in two years, at the same time that we are being asked to make major reductions in training and at the same time that we are not providing adequate access to day care. I think that it is essential that we have meaningful welfare reform passed, but I emphasize the word "meaningful." I've seen this Congress pass four different welfare reform programs since I've been here. None of them produced performance that matched the initial promise, and this exercise that we are all going through now won't either unless we provide adequate training and adequate day care, and I appreciate your leadership on that.

I would simply say that the first assignment I ever had when I became a member of my state legislature was to the Welfare Committee, and I remember one of the most interesting assignments I had was when we sat and created the first Medicaid law in Wisconsin on the task force to which I was assigned. And I guess the difference between the debate in those days and these days is that the choices that we made then were real, and the transitions that we were providing people were real, and I think the dialogue has got-

ten a whole lot further away from that and I appreciate the fact that you have kept this focused.

I also would like to say with respect to a matter in the State of Wisconsin, you mentioned in your statement "waste and fraud." I was pleased to see that the Office of Health Policy moved to review the use of taxpayers' money by a grantee in the state. It appears that there are some significant problems there, and I congratulate your agency for being on top of it.

I would hope that if that grantee winds up losing its funding, that we could work with you to find some other way to keep those services, which are supposed to be provided to people in that area. I hope we can find a way to continue to provide those services even if we have to do it through another route.

Secretary SHALALA. Mr. Obey, if I may comment on that, because our General Counsel would want me to. I am recused from the decisions that involve Wisconsin.

Mr. OBEY. I know that.

Secretary SHALALA. The Department would be pleased to work with you to make sure that the people of Bayfield get proper services.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

Mr. OBEY. Thank you.

Let me simply ask a question with respect to the conference that is now going on with your bill. That conference has tentatively approved a cut of \$419 million, 32 percent, for LIHEAP, and \$489 million, or a 17 percent cut, for Title XX social service block grant. I am concerned about the double impact that those two reductions would have on low income seniors and struggling families, and, frankly, we are still trying to get those numbers up.

Can you tell us what kind of an impact that double hit is going to have on low income seniors and struggling families who rely on that assistance?

Secretary SHALALA. Well, as you well know, it has been a very cold winter, and we have had unprecedented demands for LIHEAP money this year. States are running out of money in these areas. If there is an unusual heat spell, we will not have the resources to cover air conditioning needs in different parts of the country because of the unusual cold spell that criss-crossed the country this year.

Title XX services are directed at the most vulnerable people in our society, and they will go without, particularly the institutions that serve them. And we, of course, are deeply concerned about those cuts and just as concerned about the fact that we have had the start again, stop again process, which has made it extremely difficult to keep any kind of steadiness in funding for the institutions that serve the poorest and most vulnerable in our society.

REFUGEE ASSISTANCE

Mr. OBEY. Let me just make one additional point. I am concerned about the Federal Government's policy with respect to refugees, and I'm talking about legal refugees because I think that the Federal Government has increasingly adopted a bug-out posture with respect to its responsibility. There are a lot of things that—well, I

won't say that because it gets into personalities but let just say this.

We've seen a steady reduction in the amount of responsibility that the Federal Government assumes for dealing with the cost of refugees who arrive in this country. It seems to me that if refugees are allowed to come into this country, that is essentially a foreign policy decision. That decision is not made by state government, it is not made by local government, and yet often the consequences of those foreign policy decisions are laid very heavily on local communities, and I'll give you one example:

My hometown has a huge percentage of Hmong who have come to that area in recent years. There's a lot of controversy surrounding that fact. That controversy, I think, would be significantly more benign, less nasty, more human and more generous in terms of the attitudes that the controversy produces in people if the Federal Government was not dumping such a large cost for educating and training these new refugees on local communities. In the case of the Hmong, they don't have a written language. It is immensely difficult to try to educate them and train them.

When we had the refugee or the immigration bill before us, I tried to get on the House floor an amendment which would adopt as government practice something which was tested on a pilot basis by, among other people, Catholic charities in Chicago. What they did was to see to it that for a year after refugees came to this country they were immersed in an intensive training program and language program. As a result of that, the number of people who wound up being on welfare was reduced to extremely low numbers. We could not get that amendment made in order by the Rules Committee during the consideration of the debate on that bill, but I would like to work with you, and your people and with Secretary Riley's people so that we can come up with a common approach to try to deal with this problem.

I know that both President Bush and President Clinton tried to expand our opportunity to do that, but they were blocked by the courts because the courts felt that they did not have sufficient administrative authority to do what they were trying to do. I would like to find a way to work with you and the authorizing committee so that we can find a way to, first of all, make the way we deal with these difficult to handle refugees more realistic and more effective; and, secondly, to find a way to get the Federal Government to recognize that it has a responsibility to provide more than eight months of assistance before it essentially tosses these people onto the local tax rolls with disastrous results to both local taxpayers and the refugees who become the targets of resentment because of that Federal Government bug-out.

Secretary SHALALA. Congressman Obey, your proposal is a good one. It is consistent with what we are trying to do in welfare. There is evidence that shows that intensive front-end investments, in this transition period—whether they first come on welfare and then need to move off—it is the intensity of the front-end investment that sets someone up so that they can move successfully into the mainstream and into the work force.

So we would be happy to work with you. Right now our funding request covers, as you know, the first eight months, but that com-

bined with other programs may do the job well. And, the question is how do we combine some of the other programs?

It certainly is very much consistent with both research evidence on people going through transitions and our goals for the Welfare program.

Mr. PORTER. Thank you, Mr. Obey.

Mr. Miller?

MEDICARE REPORT

Mr. MILLER. Let me ask some questions about Medicare, if I may. The trustee's report is coming out later this year, I guess, in May or something?

Secretary SHALALA. Well, it will be later. As you know, we had long furloughs and because of the Congressional change in the earnings test, we had to go back and do complete recalculations of the numbers, but it will be coming out as quickly as we can get it out.

Mr. MILLER. Do you have any idea if it is May or what?

Secretary SHALALA. I can't give you an exact date. We were delayed by the furlough, and we have new calculations to make. I don't expect our findings to change the conclusions that we have consistently given this Congress, and that is we must move on extending our investments in Medicare to extend the life of the fund.

Mr. MILLER. Last February The New York Times came out with the article saying that Medicare is going to be broke faster, and it kind of caught us off guard that The New York Times was the source of all information.

How did we get caught off guard by that, The New York Times? I mean, did this report just slip through?

Secretary SHALALA. No, in fact, that information—what was happening to the trust fund was furnished to the Congress, and the Senate Budget Committee, for instance, made adjustments accordingly in their own baseline after consultation with the Congressional Budget Office.

Remember, these are estimates and we look at actual expenditures and flows outside the fund. Those reports are regularly provided to the Congress, and the baseline is adjusted accordingly, and what we were talking about is a number of months shift. None of that changed the conclusion that the trustees have repeated over the last three years, and that is that the issue of the trust fund should be dealt with, and the President's budget in 1997, as well as his balanced budget proposal, extends the life of a trust fund for about a decade, as do some other Republican proposals. They extend the life of a trust fund about the same amount of time.

Mr. MILLER. That New York Times report which came out said it was worse than we had thought last April. Instead of bankrupt in 2005 now it was we will find worse—

Secretary SHALALA. Well, remember, again that what the trustees do is rely on the actuary's estimates. Then we look at the actual income and expenditures from the fund. That is regularly reported to Congress, and the CBO makes baseline adjustments. In this case the Senate Budget Committee took the notification and made the adjustments to the baseline. We will see what the final report says—whether it will affect the fund by one year or a num-

ber of months—but the important point is that our conclusion has not changed. We have, as the trustees, firmly reported to the Congress that the trust fund needs to be dealt with. The President's budget, as submitted, extends the life of the trust fund for 10 years.

Mr. MILLER. Are there any changes in the way that the report is going to come up this year, or it's the same type of report?

Secretary SHALALA. There may be—

Mr. MILLER. We had trouble getting copies last year.

Secretary SHALALA. Is that right?

Mr. MILLER. Extra copies. Everybody gets one copy, and I think we needed—

Secretary SHALALA. Oh, I would be happy to provide you or members of this committee with as many copies as you would like.

Mr. MILLER. Please make sure we have enough.

Secretary SHALALA. We have two formats. One in English for the wider public and the other is the more detailed proposal.

Mr. MILLER. Right, the short one is what I'm talking about. [Laughter.]

Secretary SHALALA. We would be happy to provide you with as many copies as you would like.

Mr. MILLER. It's too bad, the politicizing of this whole issue. I mean, because we agree that it's going bankrupt and we've got to do something about it, and I've seen the ads that are being used elsewhere around the country—not in my area anyway—but it's kind of scary. I mean, I know the AFL-CIO was running the ads. I've seen them up in Cleveland, and I can't believe they would want to use scare tactics like that. It is disappointing—because you don't believe that Republicans want to destroy Medicare, do you?

Secretary SHALALA. I hope not. [Laughter.]

Mr. MILLER. What do you mean you hope not? Do you really believe that we want to destroy Medicare?

Secretary SHALALA. Well, let me say this. Some of the proposals that the Republican Party has put forward to increase the burden to beneficiaries and to allow Medicare optional plans to charge more on top while not directly destroying the program would raise the costs to individuals to the point where we would be concerned about access to the Medicare program.

Mr. MILLER. So you're saying that you think we're going to try to destroy Medicare, the plan that was passed by Congress last year? Is that what you're saying?

Secretary SHALALA. I believe that we—

Mr. MILLER. Part B or something?

Secretary SHALALA. I believe that there are proposals that Congress—

Mr. MILLER. I'm talking about the one that was passed by Congress last year.

Secretary SHALALA. I believe that there are proposals that have come before this Congress recommended by your party that would raise the burden to beneficiaries significantly. We would be concerned that low income beneficiaries would have trouble meeting the cost of their Medicare plan whether through their premiums or through the combination of their premiums plus additional costs if they chose one of the options that were available.

Mr. MILLER. So you're saying we would destroy Medicare? You think that the Republican Party would?

Secretary SHALALA. There are two ways of destroying Medicare. One is to cut it so dramatically that the providers inform us that they don't want to participate in the program so that we have less providers. The second is to raise the cost to the beneficiary to the point at which the beneficiaries cannot use the program. The average beneficiary in Medicare has an \$11,000 income.

Mr. MILLER. Low income beneficiaries are protected for the—

Secretary SHALALA. But, the lowest income beneficiaries are protected only when the Medicaid program picks up those costs. For example, under the governors' proposal, that some leadership in your party have embraced, we are not so sure that the Medicaid program will continue to pick up the costs of the Medicare premiums.

Mr. MILLER. We are not too far apart in numbers, are we?

Secretary SHALALA. Pardon?

Mr. MILLER. You are at \$124 billion. I think our numbers are around \$168 billion. That's where the number was at the White House—

Secretary SHALALA. The question is who is going to bear the burden of the slowing down of the growth—whether it is shifted to beneficiaries or whether the providers are able to handle it?

Mr. MILLER. So you're saying—let me ask you this. How about means testing Part B? I mean, you're opposed to that, I guess? You were last year.

Secretary SHALALA. Let's look at who gets Medicare in this country and how long they're living. As people get older, they get poorer in this country. The average beneficiary, again, has an income of \$11,000 a year. You have to be very careful as you add more burden. The premium may not look very heavy, but if you look at the premium increase plus the extra money that a beneficiary could be charged under options—

Mr. MILLER. How about means testing Medicare? Are you opposed to that? You all had it in your plan two years ago, but then you opposed it last year.

Secretary SHALALA. We have indicated that we would be opposed to means testing Medicare as part of a plan that also adds additional costs to beneficiaries by shifting other kinds of costs to them including putting them in a situation in which their plan could charge them on top and there would be no limits to those charges.

Mr. MILLER. I am disappointed that you're politicizing the issue so much. I thought it was only the AFL-CIO that was politicizing the issue so much. Because Medicare is too important an issue for politics and for seniors, and to say that is sad.

Secretary SHALALA. It is indeed and protecting beneficiary—

Mr. MILLER. Changing the premium from 31½ percent to 25 percent, I guess that's what you're saying is destroying Medicare?

Secretary SHALALA. No, I didn't say that. I said that you have to look at the total burden that is being shifted to beneficiaries in the Republican plan which is a combination of both premium increases—plans that would be able to charge as much as they would like on top. Also, it would take money out of the system through

medical savings accounts, which would give money to people who don't currently use the system.

Mr. PORTER. We're going to have to continue this discussion on the second round.

I'm going to try and stick within seven minutes for each member this morning. [Laughter.]

Mr. Hoyer?

Mr. HOYER. I don't get nine minutes to have fun?

Mr. PORTER. He didn't get quite nine.

Mr. HOYER. I am shocked that my friend from Florida, who has a lot of constituents who, of course, care, has not heard his candidate for President say, "I voted against Medicare, and I'm proud of that vote 30 years later," when it's been one of the most successful programs we've adopted in this country to help people stay healthy and to help them stay out of poverty. I am shocked that the gentleman expresses such incredulity that my party would think you would want to destroy Medicare when Dick Armey said, "This is a program that we ought not to have in a free society."

Mr. PORTER. I think we will go back under the five minute rule. [Laughter.]

Mr. HOYER. My Chairman, being fair, is being facetious.

I am shocked that the gentleman who wants to tell his people in Florida, "Don't worry about what my party is doing," when the Speaker says—Gingrich, of this House—with a lot of power, perhaps more than any other Speaker in history, "I want to see this program wither on the vine." Yes, we believe you want to destroy it, Mr. Miller.

Mr. MILLER. Oh, come on. That's not withering on the vine. Come on, stop politicking.

Mr. HOYER. We talk about demagoguery, hundreds of millions of dollars spent by Harry and Louise and their insurance company allies to destroy the American public's legitimate concern and looking at a program proposal.

Mr. MILLER. What is labor doing about Medicare now, spending \$35 million on Medicare?

Mr. HOYER. We are not even close to the expenditures made by the folks who are giving your party zillions of dollars.

So let me say on our side, yes, we do. The medical savings accounts you want to create are going to drive up the health care costs of everybody who is not wealthy and healthy or are going to destroy the system. Yes, sir, we believe that. You asked the question; I answered you.

Now let me say, Madam Secretary, I like a lot of your answers, by the way. I thought they were excellent. [Laughter.]

WASTE, FRAUD AND ABUSE

Waste, fraud and abuse. I want to say to my Chairman for whom I have great respect, and not only that, but great affection. He is one of our best members. I am pleased to serve on the committee with him as Chair, but he expresses the fact that he is pleased to see, Madam Secretary, that we are responding to the pressure, or the urging, or the good ideas that have been made over the last 15 or 16 months. The fact of the matter is if you read the New Covenant—now everybody has forgotten about what the New Covenant

was. The New Covenant was President Clinton's statement as he put a statement before—it was, in fact, your Contract for America, if you will. And everything, Madam Secretary, that you've said in this with respect to Welfare, with respect to waste, fraud and abuse, with respect to Medicare and Medicaid, with respect to smaller government doing it better, were all contained in that document. Now let me say to my Chairman, frankly, in one year this Administration has removed more waste in Medicare and Social Security in HHS than was done in the entire Reagan Administration administratively, not because Congress did something.

So I think we are very proud on our side of the aisle of what this Administration has accomplished.

COORDINATED SERVICES

Now, Madam Secretary, with the remaining time let me ask you a couple of questions. As you know, I am very interested in coordinated services, and I want to thank you for the participation of your Department in the effort to oversee the task force's work.

Now I want to ask you, however, above and beyond that, what efforts is your Department making to coordinate services with Education, Labor and Housing and Urban Development in particular because I think those four agencies are critical in making sure that the services we provide are rationalized at the local level so that they are much less complicated, much less regulatory and much easier for our people to access and utilize?

Secretary SHALALA. We have. In addition to our Departments working across agencies and then working within our agencies on a number of areas such as the homeless, children's programs, and management issues, we have major initiatives in a number of States. In Oregon, for example, we've given the State increased flexibility and a set of outcomes measures. A number of agencies within the States have identified performance measures. The Federal Government has given them the flexibility to reach those performance measures—those outcome measures.

We are trying different kinds of approaches with the States: from AIDS, to children's programs, to housing programs, to bringing agencies together on issues like the homeless, like immunization, for example, to help us reach actual measured goals as opposed to being so focused on the narrow categorical aspects of the programs. Our increased recommendations on program management is to give more flexibility to local communities and to fund these coordinated activities at the local level.

We believe, for example, that the remarkable increases in immunization rates are due to that kind of local and state level management that has been coordination between a number of agencies. I think it is reflected in the kind of cross country activities that the Clinton Administration has had.

In addition to that, we have enterprise zones. There are a lot of cross-country cutting areas where we sit as a cabinet with the states and with local governments to make sure that they have an opportunity to coordinate services.

Most of the States are under some kind of a welfare waiver. Seventy-five percent of the welfare recipients in this country are under a welfare waiver. We have done welfare reform using the waiver

process, and that involves very careful coordinated services, including the Labor Department's Jobs Program, the Agriculture Department's Food Stamps, to make sure that we are front-ending our commitments to move people as quickly as possible from welfare to work and to help them to stay there.

HEAD START

Mr. HOYER. Madam Secretary, my last question is—because I presume my time is over—on Head Start. I mentioned waste, fraud and abuse and the savings that have been effected.

In the previous two Administrations we were all for Head Start, but not one Head Start program was denied a grant or grant was given up because of failure to perform. I have been raising that issue, Mr. Porter has been raising that issue, others have been, and I want to congratulate you. In your statement 40 grantees have either given up because of lack of performance or have been cancelled because of lack of performance. I think that is an excellent step, not because I don't want to see those Head Start kids served in those communities, but because they will be served better if Head Start grantees know we expect performance.

My question is, you talk about the new performance standards for Head Start programs. I want to ask the question, do these performance standards focus more on outcome rather than process?

Secretary SHALALA. Actually, there are two kinds of standards that we are working with. We have done the process standards, and they actually have just been approved. Those standards direct the Head Start programs, and we provided the resources because of this committee's appropriations for quality investments. At the same time, we are in the process of outcome measures, which are complicated to do. We have brought in the best experts in the country to help us think about what those outcome measures would be and those also will be in place. We have actually simplified the standards for the program so that they are more user-friendly, and as we hold the programs accountable, it will be easier for them to understand what our standards are. We have improved the training for people who teach in the programs, the equipment, the physical facilities, all of the inputs that have been necessary that our expert committee, that bipartisan effort, told us what to do. In addition to that, we have very tough evaluations now on the program, both on the general program as well as on the new program for toddlers.

Mr. HOYER. Thank you, Madam Secretary. I think you're moving in the right direction. I appreciate that.

Thank you, Mr. Chairman.

Mr. PORTER. Thank you, Mr. Hoyer.

Mr. WICKER, for nine plus minutes.[Laughter.]

Mr. WICKER. I was about to ask how much time the gentleman from Maryland consumed.

Mr. HOYER. Seven and a half minutes by my watch.

Mr. WICKER. Close to ten.

Mr. HOYER. I thank the Chairman, however, for his timing.

NURSING HOME REGULATIONS

Mr. WICKER. I would just like to ask you about nursing home regulations. Last year I considered offering an amendment to the Appropriation Bill regarding HCFA's survey, certification and enforcement regulations, particularly with regard to the new definition of harm, and I appreciate your willingness to withhold placing five for a period of 90 days after implementation. This is one of the reasons that I withheld the amendment.

However, now that the regulation is in effect, the data are very troubling to nursing home residents, nursing home boards and a number of members of Congress from both sides of the aisle including Senators Baucus and Conrad of the Democratic Party. The data indicates that 72 percent of the nation's nursing homes have been found out of compliance.

Don't you agree that this is an unrealistic finding and that the regulations have, therefore, failed to focus in on the chronically poor performers that we all want to address? And, second, I would just point out that in my State of Mississippi 52 nursing homes were found having a substandard quality of care, but upon appeal 39 of those were reversed and this is consistent with national figures which show that a majority of HCFA determinations which are appealed are overturned.

In light of these factors, Madam Secretary, are you comfortable with the regulation as it stands now after a year of implementation?

Secretary SHALALA. I don't think you meant to say that there are nursing home residents that object to these very high standards or the rigor with which the states are now enforcing them.

Mr. WICKER. No, I definitely meant to say that because if we are being overreaching and we are not focusing in on the chronically poor performers, then the regulation isn't being—

Secretary SHALALA. First of all, we have been working with the industry, as I promised, on a day-to-day basis to make whatever adjustments that we need to make in these nursing home regulations so that they are both fair and rigorous. The industry itself is committed to that.

Because they implement the regulations, the States have focused on the most chronic problems. It is not unusual, given the kind of inspection system that we use in this country, to find nursing homes which have some problems—a large percentage that aren't up to code. Normally, under the system they make those corrections immediately. That is why the numbers go down almost immediately compared to the changes that they can make in the system.

In addition to that, what the state does then is focus on the most egregious situations, and you would be amazed how it varies. You would not be able to predict what states have the more serious problems. It has a great deal to do with whether they have been managing their inspections over a long enough period of time. It is the purpose of these regulations to focus on the most serious problems.

There have been some discussions with the nursing home industry about the way in which these definitions are laid out. Because the last thing they want is bad publicity for what they consider

minor corrections that they need to make. I am satisfied both that the standards are appropriate—the States are really moving rigorously—and that they are working closely with the industry, as we are, and that the focus really is on the most serious problems in the state and appropriate steps are being taken.

I have had no complaints from nursing home residents about the nursing home standards or from consumer groups within the States that are the advocates for nursing home residents I would be happy to go back and see if I did indeed have any complaints from the residents themselves.

We think the system is working. We also agree with the industry that in the end we need a new approach to nursing home regulations. Mississippi is a State that has done considerable experimentation on a demonstration basis with outcome measures, as opposed to the old fashioned inspection system where someone goes into a nursing home. Our ability to both get a system in place that is more modern and that fits with quality management standards is part of our discussion with the industry. We need to in the next couple of years get a new system in place. I will be meeting shortly with the HCFA people who have been working for a number of years on trying to get those measurements in place. In my judgment—and I'm sure that there are some bureaucrats in my Department that will go off the wall hearing me say this—we have to move away from this sending the inspector into the building periodically to more modern management outcome measures.

Meanwhile, I see what we are doing as transitional but also as holding everybody's feet to the fire so that we maintain high quality in nursing homes. We have found with these new standards unbelievably horrible things are still happening in nursing homes in this country. I would be very reluctant to back off because the states have gone through the training, they are satisfied with what they are working with. I would be very reluctant to back off at this point or to move away from what I think is a careful working relationship with the nursing home industry as we move through these.

Mr. WICKER. In what percentage, Madam Secretary, would you say you've found unbelievably horrible things?

Secretary SHALALA. Let me provide that to you for the record. I think you would agree that if it is one nursing home that is abusing patients in this country, that is unacceptable.

[The information follows:]

NURSING HOME REGULATIONS

Secretary Shalala: From July 1, 1995 to the present, HCFA's Health Standards and Quality Bureau received just one letter from a family member of a nursing home resident requesting that HCFA eliminate the standards. Two other family members, however, expressed general support for the OBRA '87 nursing home reform standards (sample letter attached) and three family members stated that the standards were too lenient.

In addition, twenty-six other family members of residents with dementia wrote letters expressing concern about bed rails and restraints. Relatives want bed rails kept raised because of concerns that the resident would fall out of bed. There appears to be a misunderstanding of the intention of restraint requirements; in some instances bed rails under any circumstance are being misinterpreted as a restraint. HCFA has formed a workgroup comprised of consumer and provider representatives, State survey agency staff, and HCFA central and regional office staff. It is anticipated that recommendations from the workgroup will be reflected in the policy clarifications that we issue concerning the appropriate use of restraints and bed rails. In the interim HCFA has answered each letter personally, emphasizing their understanding of the concerns of the correspondent about the safety of their relative and that it is not the intention to support any interventions that directly lead to the injury of any resident.

As of April 1, 1996, 2.5 percent of nursing homes surveyed had deficiencies that posed "immediate jeopardy" to residents. In addition, 12 percent were found with substandard quality of care. Some examples of "horror stories" in facilities with "immediate jeopardy" and "substandard quality of care" include the following:

ABSTRACTS

I. IMMEDIATE JEOPARDY

- Maryland - A resident expired due to strangulation from a Posey restraint, because the resident was not properly supervised while wearing the restraint.

A resident was placed in a Posey vest restraint, and the table top was put across the chair at 6:00 a.m. At 7:00 to 7:30 a.m., the resident was agitated and hollering. At 8:00 a.m., the resident was discovered with her head under the table top and her legs sprawled on the floor. The resident's arms were up over her head and the Posey restraint was around her neck. Her body color was yellow and grey. The resident was declared dead. Throughout the facility restraints were ordered for such reasons as stealing cigarettes from one another, leaving the grounds of the facility, and falls. The residents who were restrained to prevent falls continued to have falls with the restraints in place.

- Ohio - A resident expired on 07/22/95 due to strangulation from a vest-style restraint that was incorrectly applied.

A resident was found 07/18/95 with a vest restraint tied around the neck and chest. The resident was cyanotic, had no vital signs, no pulse, and no respirations. CPR was started, and the resident was sent to the hospital. The resident expired in the hospital on 07/22/95. During the investigation, it was determined that the facility used a medium-sized restraint when the manufacturer's directions for this resident indicated the use of a small-sized restraint. Restraints were applied without assessments for their use and without physician's orders.

- New Hampshire - 07/25/95, an abusive nurse's aide yelled at resident and refused to allow the resident to eat her meal.

During the survey of 07/25/95, certified nurse's aide told a resident to "shut up" and leave the dining room. The resident was not allowed to eat her meal and was not offered any other food until the evening meal. The group interview revealed that staff members ignore requests about care, leave disabled people at risk by leaving them in the bathroom alone for over one-half hour and delay residents from leisure time activities. Group interviews also stated that aides tell them to "shut up" and that staff are "rude" and are told to "wait that they are not the only ones."

- Florida - A resident was sexually assaulted by a nurse's aide.

A resident was sexually assaulted and found bruised and bleeding by a nurse assistant. Another resident had an attempted assault by the same perpetrator, but was unharmed. Ten other residents has multiple bruises and skin tears as a result of nursing assistants transferring, lifting, or pulling up the residents in bed.

- Indiana- Resident found with maggots in wound

During a July investigation involving a resident who was hospitalized because of maggots and larvae in a foot wound, facility staff acknowledged that the facility does not "always have enough staff to give baths" or to maintain the facility. Although the facility had been notified during March that their screens needed to be repaired to prevent flies and pests from entering the facility, the screens were still in disrepair in July.

- Ohio- Resident being fed with syringe aspirated. Staff was unaware of what to do, resident cyanotic and was hospitalized.

A resident being fed by a nursing assistance had raspy labored breathing and made gurgling sounds indicating the resident needed suctioning. Nurse attempted to suction the resident but did not know how to use suctioning equipment. Surveyor instructed nurse how to use suction equipment. Resident sent to hospital.

- Ohio-Resident left unattended in geri-walker, fell over, injured head and required hospitalization.

A resident was agitated in a geri-walker and yelling for help. The surveyor found the resident upside down with head on the floor, feet in the air and bleeding from the head. The resident was sent to the hospital with laceration on the forehead.

- Texas- Resident "force fed" with a syringe aspirated and hospitalized.

A mentally retarded resident was being "force fed." Resident was placed in a "head lock" to feed him and was told "drink this." The resident aspirated milk and became cyanotic. Neither the nurse aide or the LVN on duty knew how to operate the suction machine. The physician arrived and told the staff the resident had aspirated something and ordered the resident hospitalized.

- Maine- Widespread development of pressure sores in facility.

For 12 residents with pressure sores, all 12 had developed the sores in the facility. For 10 of these, the development of the pressure sores was found to be avoidable. Surveyors, found residents were not being repositioned. Some pressure sores were at a serious stage, and staff were unaware of some of these sores. One resident was admitted to the hospital for a skin graft for a pressure sore that had progressed without proper treatment.

Indiana- Resident left unsupervised at the top of the stairs.

At 6:50 am a resident was left unsupervised by nurses' station on the second floor. Staff thought he was "dozing." Staff report they heard a loud "crash" and when they investigated, the resident was found at the bottom of the stairs with the wheelchair on top of body. Blood pressure was reported as 140/60, but there was no respiration. By 7:00 a.m. there were no vital signs. The resident's body was removed from the facility by the coroner at 8:45 am.

- ▶ Indiana- Resident in respiratory distress left unattended for up to seven hours. Resident died.

Resident had tracheostomy, was dependent on oxygen, needed hand held aerosol treatment with Proventil every four hours. Resident was cognitively clear, able to make decisions, cooperative. Resident was found slumped over side rail of bed, no respirations, oxygen tank empty. No MD orders on how frequently oxygen saturations were to be done. No policy and procedures to address the frequency of this procedure. Resident was to receive respiratory assessments every four hours. On the day of death, there was a seven hour period with no respiratory assessment.

- ▶ North Carolina- Resident required thickening liquids to prevent choking. Not provided and resident developed aspiration pneumonia.

Resident noted to be "coughing on thin liquids." Fluoroscopy indicated "trace aspiration during coughing with thin liquids." Recommendation by therapist to place resident on thickening liquids. No record of thickening liquids could be found. Physician ordered a chest x-ray and diagnosed the resident as having "mild aspiration pneumonia and hiatal hernia."

- ▶ Hawaii- Repeated intimidation, physical and verbal abuse of residents. Administration failed to investigate and intervene.

Residents and families reported to surveyors that the staff was rude, used offensive language, and sought to intimidate residents. Residents complained of "rough treatment" by staff and reported that they were "handled abruptly." Facility policies required all complaints of abuse to be investigated. No record of any investigation could be produced and no action had been taken by administration despite repeated complaints by residents and families.

- ▶ Indiana- Resident missing from facility, found 2 blocks away.

Group interview revealed this incident which was then corroborated from the resident's chart. There was no incident report or investigation of the event. No care planning to deal with resident's tendency to leave. Two days later, resident again left. Facility again did no investigation.

II. SUBSTANDARD QUALITY OF CARE

- Washington - Resident told to urinate in diaper.

A resident about to receive therapy indicated a need to use the toilet and was told by the therapist "you can pee in the Attends." During different observations surveyors observed staff talking in a demeaning manner in the presence of other residents. For example one nurse aide, while correcting another aide's feeding techniques, said of the resident "well, she's on her way out, anyway," another nurse aide referred to a resident as "combative" but another resident said, "no she was angry."

Texas - Resident suffers extreme heat and lack of hydration.

A resident was sent to the hospital in heat distress due to lack of hydration. There were not enough staff members to implement hydration programs (they were not given water and other liquids to drink) when the air-conditioning systems broke down. Eventually residents had to be evacuated because of suffering extreme heat (changes in vital signs and increased body temperatures) for an excessive period of time and the current plan was inadequate to meet their needs.

South Dakota - Residents not provided enough food, losing weight.

Residents were not provided with enough food and are losing weight. Residents on pureed diets did not receive correct portion size and lost weight. One resident lost 16 lbs. and now weighs 75 lbs. The lack of snacks and supplements contributed to this weight loss.

Nebraska - Residents suffer dehydration for lack of adequate fluid intake.

Five of five sampled dependent residents with dementia were not provided with sufficient fluid intake to maintain proper hydration and health. One resident's medical record revealed a diagnoses of dehydration, constipation. Alzheimer's disease with dementia and was aphasic. Resident's care plan stated staff was to encourage liquids at meals and at bedside due to moderate risk of breakdown. Resident has had several infections since admitted. Initial comprehensive resident assessment revealed resident had not consumed all liquids during last three days; however, resident assessment protocols did not address hydration. The records also indicated that the resident's spouse expressed concern over resident not receiving adequate fluids. Throughout the survey, the resident was noted to have dry tongue and mouth. In addition, the resident's medication review revealed resident to be taking Lasix which has a side effect of dehydration.

- Texas - Failed to provide care in a dignified manner.

Facility failed to provide care in a dignified manner to three of three confined Total Care Residents that were showered by facility staff. Resident #1 was placed by a CNA on a shower cart that was not large enough to accommodate the resident's full body and therefore had to be placed in a fetal position. The CNA proceeded to shower the resident without first checking the water.

- Washington - Use of restraints and lack of services incapacitates residents.

Staff failure to provide the necessary exercises and services resulted in six residents who have marked decline in their abilities to walk transfer, or move in wheelchairs, and in addition to increase in contracture. One of the residents who had been able to walk independently but who had been restrained and had not been allowed to walk now required assistance. Another resident who had received physical therapy after repair of a hip fracture, was discharged from therapy in mid-July and by the August survey had already lost some ability to walk. A resident who was supposed to be getting exercises 3-5 times a week only received exercises five times in July and was unable to stand and bear weight.

- Washington - Resident not receiving care to keep independent.

Based on observations, interview, and record review, it was determined that 6 of 21 sampled residents were not provided adequate bathing, dressing, grooming, transfer, and/or ambulation to meet their needs. Referral to restorative nursing programs did not occur as they were needed by the residents, residents were not walked or provided care to keep them as independent as possible. All six residents were not provided with services that would ensure that they reach their highest practicable level of functioning in the above areas listed.

- Nebraska - Residents develop infections and bedsores.

The facility failed to provide the necessary treatment, prevent infections, and prevent new pressure sores from developing in two of four residents. One resident entered the facility with two Methicillin Resistant Staph Aureus (MRSA) infected stage IV pressure sores. This resident was observed sitting in stool and the dressings covering the pressure sores were soiled with stool. On two days of the survey, the resident sat either in bed or tilted backwards in a lounge chair with unrelieved pressure to the coccyx and buttocks area for periods exceeding two hours at a time.

- ▶ Connecticut - Helpless women residents forced to expose themselves.

In two blatant examples of a nursing home's lack of regard for the individual's right to privacy, surveyors identified situations where the facility staff exposed dependent residents to onlookers' without providing for their modesty. In the first example, a resident sat in a recliner chair with her perianal area exposed to the view of a male visitor in the room. A nurse entered and left the room without taking any action to cover the resident. In another room, two nursing aides placed a woman on the toilet in full view of her roommate. No consideration was shown for either of these women's' privacy.

- ▶ Colorado- Resident develops pressure sores in the facility, an staff fail to give needed care.

A totally dependent woman developed pressure sores on her right heel and ankle. In July, surveyors noted she did not receive either the amount of food or the mineral supplement that was ordered. The nursing staff improperly did the dressing changes, and she was left lying in the same position, without the needed pressure-reducing devices, hour after hour, further contributing to the breakdown of her flesh.

- ▶ Montana- Residents suffer severe weight loss, and facility staff fail to provide assistance with meals.

Two residents were noted to have had unplanned weight losses. One, whose ideal body weight was from 99-121 pounds, lost 22 pounds between February and April, 1995 and weighed only 92 pounds. Until July, she was still receiving small portions of food instead of the regular size portions she needed. Three of three meal observations revealed that facility staff did not assist her with her meals, and she was not able to eat her food unassisted. Additionally, snacks were not offered her in the evening as they were supposed to have been. The second resident's weight dropped to 85 pounds, reflecting a loss of 11 pounds. He was not encouraged to eat in three of three meals observed, and by the time they passed his evening snack, he was asleep. His serum protein levels were below normal reflecting longstanding nutritional deficits.

- ▶ Nebraska-Residents not given appropriate treatment to maintain their abilities to remain continent.

In the case of one resident, he became incontinent because facility was using an incontinence brief instead of assisting him to the toilet. His past history showed him to be continent. There were similar findings for other residents.

- ▶ Montana-Failure to provide sufficient nursing services.

Based on observation, staff interviews, and record reviews, the facility failed to meet sufficient nursing services for 13 of 15 residents. Nurse aides were not supervised and did not insure that the care plans were executed. Long waits for call lights and basic services such as oral care, washing hands and faces and perineal care were noted.

- ▶ Idaho-Residents not being seen timely by a physician.

The facility failed to insure that 10 of 17 residents were seen in the required time frames by their physician. One resident had no visits by a physician for 4 months. Another was admitted 12/28/94. She was seen two times in the first 90 days (1/13 and 3/5), but was not seen again until 6/5/95.

- ▶ Washington- Failure to store, prepare, serve foods correctly.

Potentially hazardous foods were not held at or above 140 degrees to prevent the potential growth of food borne illness causing bacteria. In additions, canned items were not adequately checked for abnormalities and food items were not covered when distributed.

- ▶ Nebraska- Widespread failure to prevent spread of infections.

It was observed that staff did not wash their hands and/or change gloves after direct resident contact. Staff did not wear gloves as a universal precaution against exposure to body fluids. Staff were observed touching residents and then walking to the central linen room without washing their hands before handling new linens. In addition, staff were observed using ungloved hands to hold gauze dressings next to an infected pressure sore, flushing the sore with saline, resulting in the fluid running across the wound into the gauze and into direct contact with staff members' hands.

- ▶ Nebraska- Medication error rate over 10%.

There were five medication errors out of 44 observed drugs passed. In two cases, residents were not given specific drugs because they were not available. Another resident had Paxil prescribed at bedtime and received it at 8:50 a.m. The nurse stated the medication was given at the wrong time.

December 4, 1995

President Bill Clinton
The White House
Washington, DC 20500

Re: Scrapping Nursing Home Standards

Dear Mr. President:

I realize Medicare must be cut but please don't cut Nursing Home Standards. I spent almost 5 years at a nursing home caring for my husband who suffered from a stroke and was paralyzed on the right side and couldn't speak. I was working at the time and visited him every other day, and the days I wasn't with him, I was doing his laundry. I spent every weekend with him for almost 5 years. Had I not been with him, he would have been neglected. I know the inside workings of a nursing home. Whenever the State would come for inspection, everyone shaped up - even the administration staff. I think the State needs to have an employee at each nursing home to actually see what goes on from day to day. I observed other patients who seldom had family members around and it broke my heart to see how they were neglected. I would always help other patients in the dining room to make sure that they ate.

"Training requirements for nurses and nurses' aides have been eliminate." This is absurd. Nurses' aides definitely need more training. "Nursing homes will be able to extort extra payments from the families of Medicaid patients as the price for admitting their loved one. Enforcement of standards could be left to private organizations. Inspections need to be held once every two years. This means that neglect could go unnoticed for the average life span of a nursing home resident."

WHAT IS THE PURPOSE OF A NURSING HOME FOR OUR LOVED ONES WITH THESE CHANGES???? With these changes, our loved ones will remain in bed, lay in their waste, no baths, not fed or given medication properly.

My husband passed away five years ago and still today I pray for the nursing home and the dedicated nurses, nurses' aides who are caring for these sick people who cannot care for themselves. As Jesus taught, "as you did it to one of the least of these my brethrens, you did it to me."

WHY CAN'T YOU CUT THE FRAUD IN MEDICARE? CUT THE DOCTORS AND INSURANCE COMPANIES. I URGE YOU TO LOOK INTO OTHER WAYS TO CUT MEDICARE INSTEAD OF PUNISHING THE OLDER PEOPLE, WHO MADE THIS COUNTRY WHAT IT IS TODAY. (I URGE YOU TO VISIT A NURSING HOME FOR ONE DAY)

Sincerely,


Betty Martin

Mr. WICKER. Well, certainly, and I think that is who we should focus in on. Does it trouble you and would you comment on—the fact that the majority of HCFA determinations which are appealed are reversed?

Secretary SHALALA. Well, yes, but a very small percentage are appealed all the way to HCFA. The State comes into most nursing homes, determines what is wrong, and fixes it right away. There is a difference between that and going through the full appeal process to HCFA. I can't emphasize enough that this is a State-run system under Federal oversight. The vast majority of nursing home out of compliance standards are fixed almost immediately. When we run into a nursing home that may need to be closed or has such serious physical abuses and genuine crimes that are being committed, which is a very small percentage, that it requires a lot more than simply fixing whatever the standard is. Having national nursing home standards, it seems to me, have been important. This partnership that we have with the States, I think, is also important because they are actually doing the implementation.

We have had state officials sitting with the HCFA folks monitoring the system at HCFA headquarters in Baltimore. HCFA has been working through the issues with both the industry as well as the States as we have been going along. It has been a very good and I think successful implementation effort.

Mr. PORTER. Thank you, Mr. Wicker.

Ms. Lowey?

Ms. LOWEY. Thank you, Mr. Chairman.

I want to join our Chairman, and my colleagues, welcome.

Secretary SHALALA. Thank you.

Ms. LOWEY. We are very proud of the outstanding work that you are doing, and I am pleased that the Administration continues to place such a high priority on the health and social issues of this nation.

We would be fooling ourselves, Democrats and Republicans, if we didn't respond to the real frustration and anger of the American people, and I am pleased to know that while this Congress continues to consume itself with simplistic rhetoric and not get that much done, you are really getting things done. I was particularly pleased to hear about the 37 waivers for welfare reform. Certainly in New York and Westchester County, we are doing some important work with welfare reform, work fare, as well as in other parts of the country. I am very pleased to hear that you are cracking down on waste, fraud and abuse because let me tell you at every meeting I go to in my district, you hear people complaining about one thing or another, and waste, fraud and abuse is what gets people so skeptical and so angry. They feel that their money is going into a dark hole, and so your responsible work, cutting out waste, fraud and investing in research, such as cancer research, and the coordination which you've put in place really makes us proud, and that is going to increase the confidence of the American people.

BREAST CANCER SCREENING

I want to focus on a couple of things that you are doing. As you know, I have been a major advocate for breast cancer research, and I am deeply committed, as you are, to winning the war against

breast cancer and all forms of cancer. We have made some progress in fighting this disease—certainly, for example, the discovery of the breast cancer gene—but we know that one in eight women will still contract this disease. Your Department is at the center of the Federal Government's efforts, through the research activities of the National Institutes of Health, the screening program at the Centers for Disease Control and the coordinating function of the Office of Women's Health.

I think it would be helpful if you could update this committee on the Department's activities in the fight against breast cancer and the way in which these agencies are working together because I think this coordination has been vital in producing so much of the success and also cutting out a lot of the waste.

So I thank you.

Secretary SHALALA. Well, we have had very careful coordination between the National Cancer Institute and the Centers for Disease Control, and Prevention, which has much of the prevention activities, and our own office of Women's Health. We have identified a number of priority areas for research, as well as priority areas for consumer information. One of the reasons why we have made some progress in this country is because the FDA took on the responsibility to make sure that mammogram machines were up to code. The Centers for Disease Control and Prevention and other agencies coordinated Breast Cancer Awareness Month, as well as the other information that has gotten out. The breast cancer screening rates are the highest in American history. Mortality has, for the first time, started to decline. These investments in research, in screening, in prevention, getting people to screening has made a difference in mortality rates. Since 1989 we have had the largest short-term decline in 40 years, and we think that is because of advances in chemotherapy, in hormonal treatments and access to mammography. I think that for the first time we may see an actual steadiness or maybe even some decline in the number of minority women who are getting breast cancer. That will be a major breakthrough, and that means that the message has gotten out and more people are getting access to mammography and to early detection. Let me tell you a couple of things about the kinds of campaigns.

The postal service is going to issue 100 million breast cancer awareness stamps as part of our breast cancer awareness campaign. In 1997 CDC will spend \$125 million for breast cancer and cervical cancer prevention activities. That is a 75 percent increase since 1993. Our national action plan is part of that, and I think that this kind of awareness aimed at women but also at the men who care about them has really made a difference, and we can see it in earlier detection and in our mortality rates going down.

TEEN PREGNANCY PREVENTION

Ms. LOWEY. I thank you, Madam Secretary. Another area where I have been focusing, as you are, is in the whole area of teenage pregnancy and what we do about it. I know that you join the President in his commitment to addressing this serious problem facing our country. It affects young women as well as the future of children who are born to teens.

The President in the State of the Union spoke of the importance of public-private partnership, and clearly we can't solve this problem alone. I was pleased to see that your Department is requesting \$30 million for demonstration grants to target areas with high teen pregnancy rates, and of these funds \$5 million will go toward evaluation.

Can you tell us about this new initiative? How will these grants involve different sectors of the community and what types of activities will be funded?

Secretary SHALALA. The new funds will be targeted to areas of the country that have very high teen pregnancy rates. We're talking about urban, suburban and rural areas where collaborative efforts or inter-agency linkages are already in place or just beginning. We evaluated all the teen pregnancy programs in the country last year to find out what we knew and what we didn't know. We know that community-based collaborative efforts can have an impact on teen pregnancy rates if they are sustained. And, they are not seen as just a narrow program which gives information to teenagers, but one which integrates lots of other activities. For example, a rural county in Oregon in conjunction with the State of Oregon as part of our overall management demonstration, identified itself as having some of the highest teen pregnancy rates in the whole State. The community came together and every organization within the community—the schools, the religious organizations, the Kiwanis, other service organizations, and the health care professionals—in an integrated strategy to work on the issue of teen pregnancy. Their rates are coming down.

So, what we intend to do is support what is growing around the country, and that is collaborative efforts by communities, public-private partnerships coming together to deal with issues of teenage pregnancy in their communities. It is more than simply providing information to parents. Our goal is to strengthen parental resources and to use every institution in the community to send a very clear message to teenagers and to keep them busy. Our objective is to keep them focused on future goals—getting a job, going to college, getting themselves together and making it very clear that society feels that having children is the responsibility of adults once they are both financially and emotionally prepared to take on the responsibility within the context of marriage.

We have proposed an additional \$30 million to strengthen these activities and to develop model programs. It is different from some of the other initiatives that we have, but it will be carefully coordinated within the Department.

In addition to that, the President has lit a fire under a private sector initiative. There is a national effort, by leaders in the private sector to have a national campaign on this issue. But, again, sustained local efforts are what will make a difference.

Ms. LOWEY. I don't know if I am up to seven or nine minutes, Mr. Chairman, but I just want to say one thing in closing, that I am particularly pleased that you have the evaluation component. I have met with Elaine Bennett, and she is doing some outstanding work in this area. There are many really good programs. The Johnson & Johnson Foundation has received thousands of proposals from teen pregnancy prevention programs for evaluation funds.

They can't respond to all the requests and people are begging us, begging me, begging you, I am sure, to evaluate some of these programs.

So I think it is important that we learn what works, what doesn't work, so we can base future programs on our successes.

And I thank you, Mr. Chairman, and thank you again, Madam Secretary.

Secretary SHALALA. Thank you, and let me also say on evaluation, Mr. Chairman, that one of the things our full study of programs and what seems to work revealed was that there is very little rigorous evaluation in the area of teenage pregnancy. We know that this has to be built in as part of these new efforts.

Mr. PORTER. Thank you, Ms. Lowey.

Mr. Bonilla?

Mr. BONILLA. Thank you, Mr. Chairman.

Good morning, Madam Secretary.

Secretary SHALALA. Good morning.

ROLE OF SURGEON GENERAL

Mr. BONILLA. It's nice to see you again. I would like to start out by complimenting you on a statement that you made last May when you said, quote, "What we are going to do is focus on health outcomes as opposed to the regulations." I applaud that approach and appreciate your efforts to merge some of HHS' operations and eliminate entire management layers. I think it is something that we can all agree on this committee is the right direction that you're taking HHS.

My first line of questioning is about the Surgeon General's position. I heard the President say recently that he did not intend to nominate anyone for Surgeon General this year.

Madam Secretary, who needs a Surgeon General when we have people like you? You regularly visit classrooms and board rooms, you emphasize prevention from infant immunization, to annual physicals, to mammograms, to pap smears. You are critical of negative behavior, drug abuse, tobacco, poor diet, drunk driving, teenage pregnancy and failure to exercise. You have issued medical alerts regarding increased HIV infection rates among young adults, and you have even released a series of national and radio ads aimed at young adults in the high risk category for AIDS.

So my question is, why don't we just eliminate the position of Surgeon General since you and others at HHS, like Dr. Satcher, are doing such a great job of getting the word out?

Secretary SHALALA. Well, we need a new Surgeon General, and we need to make sure that we maintain that position. We do have an acting Surgeon General, Audrey Manley, who is doing a terrific job.

As you know, the Surgeon General has the responsibility for policy development and oversight of the Commissioned Corps. In fact, in that reorganization that you referred to, we have strengthened the role of the Assistant Secretary for Health and the Surgeon General in a leadership position targeted on prevention and on public health so that it is targeted. For example, the Surgeon General will issue a major report just before the Olympics on exercise.

There has been a tradition of this country listening to what physician's views are on issues of prevention. I think the Secretary is too thinly spread out and the special prevention role of the Surgeon General must be continued. The President did make a decision not to make a political nomination this year, but we continue the office and continue the very strong role of the Surgeon General in pronouncements. I think you will see that when the Surgeon General issues her report on exercise, that the country listens to the Surgeon General and the Secretary listens to the Surgeon General. It is a very special role in this country, and it should be continued.

Mr. BONILLA. Well, what is the difference between eliminating the position and the President not nominating someone permanently for the position for an entire year? If the President doesn't think it is a priority, why can't we just eliminate it? What is the benefit?

Secretary SHALALA. I think that there are a number of positions that aren't necessarily filled right away and that the President believes that we should continue that position, and we in the Department believe that we should continue that position. The political reasons for not making the nomination are somewhat obvious, but we really believe that the Surgeon General's position is a critical one for the nation's health, and it should be continued.

TOBACCO USAGE

Mr. BONILLA. I would like to turn now to the subject of tobacco, and, once again, I would like to preface this by saying that I have no parochial interest in this issue at all. My concern is just about Federal dollars being spent on something that is perceived to be a politically correct cause, and my concern is also one of fairness.

On page eight of your testimony you talk about the tobacco initiative by supporting innovative community partnerships that give children the facts about a deadly addiction that could take years off their lives. Now I agree that young adults under the age of 18, and everyone agrees, need to be educated about tobacco and should not be smokers. However, after the age of 18 I believe that everyone has a right to make their own decisions about how they live their lives whether they want to smoke, or eat bacon, or lard or anything else that may be detrimental to their health. They should make this decision with the understanding that it could cost them some time off their lives and in the short-term probably cost them higher insurance rates and tougher health problems.

AMERICAN STOP SMOKING INTERVENTION STUDY (ASSIST)

It brings me to a few questions about ASSIST, the American Stop Smoking Intervention Study Program.

In 1993 my colleague, Helen Bentley, raised her concern about ASSIST funds being used to lobby at the state and local levels. Your response left no room for uncertainty—no funds would be used to lobby. Furthermore, you stated that ASSIST contracts contained references to the appropriate sections of the Federal acquisition regulation, which indicate that lobbying activities at the Federal and state level are prohibited. It was clearly pointed out.

Is it still your policy that Federal funds shall not be used for lobbying at the state and local levels?

Secretary SHALALA. It is the law.

Mr. BONILLA. In addition to your comments, I have a copy of a memorandum from a contracting officer at NCI to ASSIST project directors which contradicts your statement and the law.

My question for you is who sets policy at HHS? You said it is the law, but is it or should the project officers be operating on their own; what actions are you going to take to make sure that Federal funds are not used to lobby state and local officials?

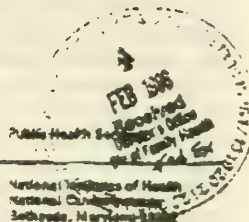
Secretary SHALALA. I would be happy to take appropriate actions if you would furnish me with that information.

Mr. BONILLA. I would be happy to provide that for you and will do so. I have a copy here and I won't bore the committee by reading the letter, but I would be happy to provide that memorandum for you.

[The information follows:]



DEPARTMENT OF HEALTH & HUMAN SERVICES



Date: January 30, 1996

To: ASSIST Project Directors
 ASSIST Project Managers
 ASSIST Coordinating Center

From: Theresa R. Shroff
 Contracting Officer, RCB HCI

Subject: Federal Acquisition Streamlining Act of 1994
Cost Principles

We have received inquiries from several ASSIST states concerning the possible impact the passage of the Federal Acquisition Streamlining Act (FASA) of 1994 might have on their contracts. The purpose of this memorandum is to clarify issues pertaining to the applicability of the FASA to the ASSIST contracts.

The FASA resulted in an amendment to Part 31 of the Federal Acquisition Regulations (FAR) which deals with contract cost principles. However, the new cost principles apply only to contracts awarded on or after October 1, 1995. Since the ASSIST (prime) contracts were awarded in September 1991, it is clear that the new cost principles do not apply to FCI's contracts with the ASSIST states. A question remained concerning the applicability of the new cost principles to subcontracts, including subcontracts executed on or after October 1, 1995. The Office of General Counsel, Department of Health and Human Services, has advised that the language that exists in the FASA statute supports the conclusion that such subcontracts are not covered by the amendment since the ASSIST prime contracts, which were awarded prior to October 1, 1995, are not covered by the amendment and that ASSIST prime contractors are not expected to pass on the new cost principles to subcontractors.

You are advised to continue to refer to the March 1993 Restrictions on Lobbying and Public Policy Advocacy by Government Contractors: The ASSIST Contract document.

Any additional questions should be addressed to the Contracting Officer or your HCI Project Officer.



STATE OF NEW YORK DEPARTMENT OF HEALTH

Office of Public Health

Corning Tower

The Governor Nelson A. Rockefeller Empire State Plaza

Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

February 5, 1996

Coalition Project Directors and Contacts:

I am very pleased to be writing to you with new information regarding limitations on policy advocacy activities by local coalitions.

In October, I wrote informing coalitions that new regulations adopted by the Federal government under the Federal Acquisition Streamlining Act (FASA) of 1994 appeared to prohibit the use of ASSIST contract funds for purposes of lobbying state and local elected officials. This information was based on a preliminary opinion provided us by the National Cancer Institute (NCI).

I am happy to tell you that a final interpretation of the regulations by the Department of Health and Human Services has determined that contracts awarded prior to October 1, 1995 are not subject to the FASA and, therefore, these regulations do not apply to contractors or subcontractors participating in the ASSIST program. A copy of the explanatory memo from the NCI Contract Officer is attached.

The effect of this clarification is that we continue to operate under the cost principles in place at the beginning of this project. I will review these principles and their implications for your coalitions at this time. As this project matures, coalitions are becoming more and more involved in policy advocacy, and it is important that coalition leadership understand the parameters within which we all work. Please take the time to review this letter carefully.

First, it is important to understand that Federal law and regulations determine contract "cost principles." Cost principles are used by the funding agency (in our case the NCI) to determine which contractor expenses are reimbursable with contractually awarded funds, and which are not. A contractor is not prohibited by these cost principles from engaging in lobbying activities, but limits are placed on the type of activity for which NCI will reimburse the contractor.

"Lobbying" is defined as any attempt to influence the introduction or enactment of legislation through communication with any member or employee of an elected legislative body or with any government official or employee in connection with a decision to sign or veto enrolled legislation, or attempting to influence such activity by preparing, distributing or using publicity urging others to take action to influence the introduction or enactment of legislation.

Federal contract funds may never be used to influence Federal legislation. Coalitions may not bill the contract for any costs connected to lobbying Congress or the Executive branch regarding legislation. Costs associated with communicating with the Executive branch regarding regulations, such as the proposed FDA regulations on tobacco product marketing, are reimbursable.

Costs associated with lobbying with regard to local (county, city or town) legislation are allowable under these cost principles. Coalitions may use contract funds to communicate with elected officials or employees of county legislatures, town or city councils, etc., and with county executives or mayors regarding local tobacco control legislation. Contract funds may also be used to urge members of the general public to support such legislation and to communicate their support to local officials.

With regard to lobbying state legislators and the Governor, coalitions fall into two different groups, depending on what type of agency holds the subcontract. If the subcontracting agency of record is a county health department, a hospital or an educational institution (such as BOCES), the coalition may use contract funds to lobby state officials and to urge members of the general public to do so. If the subcontracting agency of record is a non-profit organization incorporated under section 501 (c) (3) of the IRS code (such as the American Lung Association), the coalition may not use contract funds for such purposes.

Enclosed with this letter is a document previously distributed to coalitions, "Restrictions on Lobbying and Public Policy Advocacy by Government Contractors: The ASSIST Contract." Keep this document on file with your contract for future reference. See especially pages 10 - 13 for concrete examples of activities permissible and impermissible for reimbursement under the cost principles.

Note these cost principles determine only what costs NCI will pay. They do not prohibit a coalition from taking action on its own. Thus, if a coalition wishes to communicate with a member of Congress regarding tobacco control legislation it may do so, but it may not bill the contract for any expenses associated with the activity. Persons paid with contract funds may not participate in drafting or preparing the correspondence. The correspondence may not be written on stationery purchased with contract funds, and postage may not be paid with contract funds.

Because it may sometimes be difficult to separate activities funded by your ASSIST contract from activities supported by member agencies, coalitions should exercise caution and maintain good documentation when engaging in lobbying activities not reimbursable under the ASSIST cost principles. For instance, if a coalition wishes to communicate with a member of Congress regarding legislation, it should assign the task of drafting and typing the correspondence to a person not compensated by the ASSIST contract. Coalitions should consider having a separate agency or individual purchase one or two reams of coalition stationery for such purposes. The stamp on the envelope should be bought by an agency or individual not receiving ASSIST funds. Careful notes should be kept of these matters for future reference.

Do not underestimate the possibility that the tobacco industry will accuse coalitions of illegally using contract funds for lobbying. Such charges have been formally raised in three ASSIST states. In two the allegations were found by authorities to be unsubstantiated, and in the third a decision is pending.

Good documentation of how policy advocacy activities are funded will help you avoid even the appearance of impropriety. Our goal is to keep public attention focused on the health effects of tobacco products and the need to protect the public through effective tobacco control policy. We

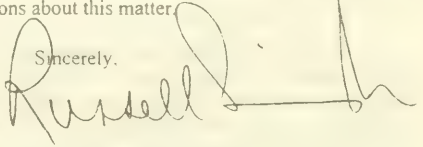
- 3 -

must not allow the agents of the tobacco industry to distract the public and policy makers by raising questions about your use of public funds. What is strictly legal in this regard may not be prudent, in a public relations sense.

This news should encourage all coalitions to redouble their policy advocacy efforts. All coalitions may use contract funds to appropriately advocate for tobacco control at the local level, and most may do so at the state level. Local legislation, regulation and voluntary policies are the cornerstone of our effort to eradicate tobacco-caused disease. Your vigorous advocacy for tobacco control is the key to our success.

Please share this important information with all members of your coalition. Feel free to call me at 518-474-1515 should you have any questions about this matter.

Sincerely,

A handwritten signature in dark ink, appearing to read "Russell", followed by a long horizontal line extending to the right.

Russell Sciandra, Director
Tobacco Control Program

cc. Field Staff

ASSIST CONTRACTS

Secretary Shalala: Policy and legal staff have reviewed the memorandum from a contracting officer at NCI to ASSIST project directors which was brought to the attention of Secretary Shalala. They concur with her statement that Federal funds will not be used for lobbying at the federal, state and local levels in any manner which would violate federal laws.

In 1993, NCI with the concurrence of the HHS Office of the General Counsel issued a detailed analysis entitled "Restrictions on Lobbying and Public Policy Advocacy by Government Contractors: The ASSIST Project." This analysis has been our guide for interpretation of the federal lobbying restrictions as they apply to the ASSIST program. The guide provides examples of permissible and impermissible actions.

In 1995 the Federal Acquisition Streamlining Act extended lobbying restrictions to the local level. In response to inquiries concerning the impact of this legislation on the ASSIST contracts, HHS General Counsel was again asked to provide guidance. The pertinent part of their analysis, published in January of 1996, states "We conclude ... that the new cost principle, insofar as it adds local legislative lobbying costs to the list of unallowable contract costs, does not apply to contracts that were in existence prior to October 1995. ...[t]he FAR Council had the authority to determine whether the new cost principle would be applied retroactively and elected not to do so. You have also asked whether the new cost principle must be applied to subcontracts that are executed on or after October 1, 1995 by prime contractors whose contracts are not themselves covered by the FAR amendment, because they were in effect prior to October 1. While there is very little in FASA and nothing in its legislative history or the regulations to aid us in answering your question, we believe that such language as does exist in the statute supports the conclusion that such subcontracts are not covered by the amendment...." The memorandum from the contracting officer at NCI transmits these findings to the ASSIST project staff and advises them to continue to use our 1993 lobbying restriction guidelines.

To make sure that Federal funds are not used for impermissible lobbying the Financial Advisory Services Branch at the NIH conducted pre-award audits of the ASSIST contracts. A final audit will also be conducted at the time of contract closeout. In the interim, HHS staff review the monthly invoices and budget summaries.

In conclusion HHS has taken affirmative steps to make sure that the ASSIST contractors understand the distinction between permissible and impermissible lobbying activities, and make sure that Federal funds are spent appropriately.

Mr. BONILLA. Thank you very much, Madam Secretary.

Mr. PORTER. Ms. Pelosi?

Ms. PELOSI. Thank you very much, Mr. Chairman.

I want to associate myself with the remarks of my colleague, Mr. Bonilla, up until when he said what is the need for a Surgeon General? [Laughter.]

ACQUIRED IMMUNODEFICIENCY SYNDROME RESEARCH

Ms. PELOSI. I, too, was thinking before I heard him speak that I didn't want to sound too much like a fan and sing the praises of our distinguished Secretary of HHS, but you indeed have done such an excellent job providing such great leadership. I say that as an observation. I commend you and thank you for all that you have done.

I appreciate your full statement where you make a comment about the Office of AIDS Research and the commitment of the Administration to funding our AIDS research through that office.

The Levine Report, which was released last month, makes it very clear that we must continue to increase our commitment to AIDS research at NIH. The Levine Report also makes clear the need for a strong Office of AIDS Research with full authority granted to it by the NIH Revitalization Act. As I mentioned, you made a strong commitment to it in your comments and the President expressed his strong support for Dr. Paul and the authority of the OAR. For the first time since the beginning of the AIDS epidemic, there was an "institute-without-walls", with a director in charge of the entire NIH AIDS research program.

Again, I want to commend you for that. It is my understanding that in the negotiations for the 1996 Omnibus Appropriations Bill that the White House is asking that the consolidated OAR be restored for fiscal year 1996. I hope this will be the outcome.

In your view, in what ways would resolving the ground rules on the authority for the OAR now—rather than later—be of assistance to all involved in research at NIH?

Secretary SHALALA. I think, Congresswoman, as you pointed out, the Levine Report, which reviews our AIDS research over the years, emphasized and underscored the importance of having a strong Office of AIDS Research with a unified budget authority to coordinate and lead those efforts. As the report pointed out, and as we have repeated, AIDS research is done in most of the institutes. For that AIDS research to be effective, it requires strong scientific leadership, in our judgment centralized with a uniform budget. The Levine Report even reinforced that point and the need for very strong scientific leadership.

The President has repeated that. I don't know what the outcome of the final 1996 resolution is going to be, but our support is for the Office of AIDS Research and for a unified budget. I can only repeat again that we argue for it for scientific reasons now. When we originally came before this committee 3 years ago, we believed that from a management point of view—with all the cross-cutting—it was important.

I think we have major scientists in this country who have looked at the research and have reinforced the connection between science and that organizational unit. I think that is an additional and even

stronger argument for keeping the Office of AIDS Research and first-class science leadership at the top of it.

Ms. PELOSI. On a related issue, recent AIDS research has documented the ability of new combination therapy to improve health and greatly improve the quality of life of people with HIV and AIDS. The Administration is to be commended for requesting the \$52 million in funding for the AIDS program.

Mr. Porter, as our chairman, you are to be commended once again for your leadership in providing these funds for the remainder of the fiscal year.

What plan does the Administration have to look at the projected cost of these new therapies and make modifications to the fiscal year 1997 budget request to assure that people who benefit from these new therapies have access to the new drugs?

I might add that as generous as the \$52 million is, it is for half a year. So for fiscal year 1997 we would need at least \$100 million to respond to projected need.

Secretary SHALALA. We have made a request for fiscal year 1997 of \$52 million.

Let me say something about these drug therapies and about our conversations with States. We are providing resources. They are beginning to run out of resources for supporting drugs in their own programs.

We have made an estimate, based on what limited information we have about the cost of the drugs and when and how they are going to be used. This new class of therapy, which I am sure the scientists who will testify for NIH can explain when it should be used, in what combinations, how early, how late, for how long a period of time, what the dose arrangements are.

We are making an estimate based on the scientific evidence we have to date. As the drug companies start to work out their pricing mechanism, we will be watching it carefully. We will come back to this committee with the State and territorial public health officials if we think there need to be adjustments in those amounts.

But we certainly do not want to withhold from people in this country an opportunity to extend life, which is the hope of these new drugs. We have made an educated guess on what we think we will need in fiscal year 1997, but it is quite possible that we may come back to this committee during the course of the year as we work with these drugs. I think the NIH people can provide a little bit more information.

Ms. PELOSI. I appreciate that because this committee has invested a great deal of money into AIDS research. Now that we are having some pay-off, I think it is very important for us to have an adequate amount of money to benefit from all the research that has been invested in.

Secretary SHALALA. Just to give you a sense of how much money we are talking about, the AZT per month cost was about \$300. Now, we estimate that the cost is between \$500 and \$600 a month so, there is a difference. What we need to do for all of you is to pin this down. We have made an estimate, but we will come back. If what we are talking about is saving lives, I am sure this committee and Congress will want to respond.

Ms. PELOSI. I believe that we have a moral responsibility, once we know how we can improve the quality of life, prolong life, and hopefully provide better intervention or a cure to provide this to people.

Secretary SHALALA. Again, there is a lot we don't know about these drugs in terms of the optimum time to start the use, whether they really rid the body, not just the bloodstream, of HIV. There is a lot we still need to know.

BREAST AND CERVICAL CANCER SCREENING

Ms. PELOSI. I wanted to get in another question about breast and cervical cancer screening.

As you know, the program enjoys a great deal of support on Capitol Hill. It came out of the authorizing committee without a dissenting vote. The program seems to work. It got a 25 percent increase from our chairman. People who avail themselves of the program seem very satisfied with it. That is why I was very concerned that the budget request changed the program to a performance partnership grant.

Could you comment on why you would change a successful program that has enjoyed support on Capitol Hill that is viewed favorably by those who need it and which received an increase from the committee?

Secretary SHALALA. A number of our most successful programs are being turned into partnerships with the States so that we can measure outcomes. It really is a management tool for us. We expect it to be even more successful in the future. I think the results of these investments are already being seen in morbidity and mortality reports that are coming in.

We are moving to a different relationship with the States where we are going to measure outcomes, not simply fine-tuned inputs. In a number of areas in the Federal Government, we are trying to modernize the management of Federal dollars so that they are used more effectively and in coordination with other programs at the State and local level.

We would be happy to discuss that further with you at any point.

Ms. PELOSI. I appreciate that.

Thank you, Madam Secretary.

Thank you, Mr. Chairman.

[The information follows:]

BREAST AND CERVICAL CANCER SCREENING

Secretary SHALALA. The intent of the proposed performance partnership grant is to provide states with increased flexibility over how they use grant resources for chronic disease and disability prevention while maintaining accountability for program performance. States and CDC will work together to achieve mutually agreed upon objectives for reducing preventable death and disability, enhancing quality of life and reducing disparities in health status in our society. Currently, we are meeting with our partners around the country to begin to develop a list of desired program results, including health outcomes, which can then serve as the basis for performance partnership agreements.

CDC has made great strides in establishing an infrastructure that supports early detection of breast and cervical cancers at the national, state, and local levels. This infrastructure will serve as a foundation to support continued efforts in a consolidated grant environment. The control of breast and cervical cancers is viewed as important throughout the country by both the public and the public health community. I am confident that the interest of the public health community and other groups

concerned about these health problems will help to ensure the continued viability of this important effort to reduce morbidity and mortality from breast and cervical cancer for the women of this nation.

Mr. PORTER. Thank you, Ms. Pelosi.

Mr. Dickey?

Mr. DICKEY. Thank you, Mr. Chairman.

Good morning, Madam Secretary.

RESEARCH

Secretary SHALALA. Good morning.

Mr. DICKEY. Last year, you provided us information showing that in fiscal year 1994, \$39,172 was spent per HIV/AIDS death, while only \$3,776 was spent per cancer death, and \$1,056 per heart death. Cancer caused 520,578 deaths in 1992 while HIV/AIDS killed 33,566. Why is there such a large discrepancy in the proportion of funding spent on AIDS research compared to other diseases?

Secretary SHALALA. We don't believe that our investments in research on AIDS is out of balance with other diseases. The public health impact and the value of dollars spent on any disease has to be assessed through a series of measures, including mortality and morbidity, the incidence and prevalence rates, the cause and mode of transmission, fatality rates, years of potential life lost, demographic factors and research opportunities. It is inappropriate in our judgment to use any one of these criteria independent of the others.

AIDS is still a growing epidemic in this country. It is infectious because it mutates so quickly. It disproportionately kills younger people. It is now the leading cause of death for people between 25 and 44 in this country. It has wide impact beyond the diagnosis of a single disease. It contributes to other kinds of public health crises, including TB and other sexually transmitted diseases, drug abuse, and infant mortality. It is a growing burden on the public sector, in particular.

As we have pointed out in the past, the research and the investments produce spin-offs for other kinds of diseases. I think our fundamental point on AIDS is both that it helps our research on other kinds of diseases and these are the measures of where this country invests—it goes way beyond the mortality and morbidity reports. In particular, it has tremendous impact on our society.

Let me also remind you that AIDS is increasingly a world-wide disease. The face of AIDS in this country is changing. It will be increasingly women and young children. Our investments are already paying out to save babies' lives. The new research breakthroughs have produced a way in which we can help pregnant women so that they don't deliver AIDS babies. There are drugs now that appear to extend life for a whole generation of young people in their most productive years.

These investments are absolutely critical.

FIREARM INJURY STUDY

Mr. DICKEY. On page 10 of your statement, you mentioned that \$88 million is the figure for CDC's national research, surveillance, and prevention efforts against the diseases that exist in 30 States.

Secretary SHALALA. I think that we are talking about emerging diseases, the Ebola outbreak, the Hanta virus—some of these new and emerging diseases. We have recommended a doubling of our expenditures plus renovation of the laboratories in these areas.

Mr. DICKEY. I really hadn't finished my question.

Secretary SHALALA. I apologize.

Mr. DICKEY. CDC Director David Satcher asserts that CDC evaluators have found the firearm studies of Dr. Arthur Kellerman outstanding and among the best work the CDC has funded.

There are several questions I want to ask in this regard.

Secretary SHALALA. Okay.

Mr. DICKEY. Of this \$88 million how much is going to be spent on firearm studies?

Secretary SHALALA. I think that the number you are referring to is for the emerging diseases part of CDC.

Mr. DICKEY. Are they different?

Secretary SHALALA. Yes, they are, absolutely.

Mr. DICKEY. I apologize, then.

How much is being spent on firearm studies?

Secretary SHALALA. I will find that out for you and provide you that for the record.

[The information follows:]

FIREARM INJURY PREVENTION

Secretary SHALALA. The National Center for Injury Prevention and Control at CDC spends \$2.6 million on firearm injury prevention. That's about 5 percent of its \$46 million budget. Most of NCIPC's funding is spent on preventing falls, fires and burns, drownings, injuries from motor vehicle crashes and family and intimate violence and youth violence. While the efforts to prevent family and intimate and youth violence may ultimately reduce violence committed with firearms, these efforts are not directed specifically to firearm injury prevention (other than the \$2.6 million already mentioned).

Mr. DICKEY. Are you aware that other scholars question Dr. Kellerman's results saying that they do not appear to square with those portions of his data published as supporting them? And are you aware that Dr. Kellerman is refusing to give the data that supports his opinion?

Secretary SHALALA. As far as I know, CDC has always supported very high quality scientific research. I don't know the specific study you are referring to, but I would be happy to provide you a response for the record.

Mr. DICKEY. We want to find out if he is legally able to refuse to give the data that is supporting his opinions, particularly since they are funded by public funds. His work is funded by public funds, and I am somewhat confused by the fact that he is refusing to give that data.

Did you know that he has been refusing to give that data?

Secretary SHALALA. No, I did not. And I am not aware of the situation. But I would be happy to provide answers for the record.

[The information follows:]

FIREARM INJURY STUDY

Secretary SHALALA. Dr. Kellerman and his colleagues are CDC grantees, not contractors. They intend to release the data from their research after their analyses are completed. They are now finishing their analyses and preparing to release the data late this year. Dr. Kellerman and his colleagues are receiving federal grant

funds, but they are not required to provide data early to the Department of Health and Human Services (DHHS) in order to respond to a request for the data to DHHS by a third party.

Mr. DICKEY. Thank you, ma'am.

What is your position on human embryo research?

Secretary SHALALA. The President has indicated that he does not believe that human embryos should be developed for the purposes of research. We have an Executive Order on that. The NIH has not been funding research in this area.

Mr. DICKEY. Are you going to make any effort to revive that issue?

Secretary SHALALA. The President's Executive Order stands on the very narrow issue.

Mr. DICKEY. And that is indefinite? Is that right?

Secretary SHALALA. There is no time limit on the President's Executive Order.

EXCEPTED PERSONNEL

Mr. DICKEY. Did you make an evaluation, Madam Secretary, when we had the Government shut-down as to how many essential and non-essential employees you had in your agency?

Secretary SHALALA. We did. I could provide you with those. I am not sure I have those numbers with me. It was a very difficult period, whether or not they were excepted or non-excepted. As you can imagine, in an agency that essentially does a lot of contracting out, we have had to repeat steps and functions that we have had 12 different times. Frankly, it is a terrible way to run an agency of any kind. I am sure you agree.

Mr. DICKEY. I do.

How is the general morale of the personnel of your agency right now? How would you describe it?

Secretary SHALALA. I would describe it as anxious. I would describe it as anxious because we are on our 12th CR and are very anxious to get a budget. But people continue to perform their functions.

As you know, we have had two major tragedies in the public service, both in Oklahoma City and more recently with Secretary Brown's plane. I think public servants in this country have felt those disasters very personally and that we need to get on with the business of Government and get our budgets funded.

Mr. DICKEY. This business of serving the public is kind of difficult when they are asking for us to balance the budget and also keep the services going. Would you agree with that?

Secretary SHALALA. It is, but let me be fair about that. For those of us who came from State government, for example, we have spent much of our careers downsizing. There is a difference between State budgets and the Federal budget, as you well know, in terms of balance because our capital budgets at the State level were not in our operating budgets, as they are here.

The kind of work we are doing—which is tightening up, selecting out priorities, dropping and reorganizing those things that are not absolutely essential—is appropriate. The Federal Government should have done it years ago. I have no problem.

I do have a problem when we go through this kind of stop-and-start funding. If the leaders of this country want the agencies to do what I believe is appropriate—and that is to be tougher in management and to choose priorities—then we need the steadiness of the money coming in. There is a difference between what levels of funding are coming in and the steadiness of the funding. Having employees that are in and out is very difficult, particularly because we are downsizing and reorganizing.

Mr. DICKEY. Did you classify as essential the press secretaries in your department?

Secretary SHALALA. It may have been one person, but I don't think we had many more than one or two people in the department. I think almost all of them were off during the furloughs.

Mr. DICKEY. What titles did you describe as being non-essential?

Secretary SHALALA. We had a set of standards that we met that each manager was given in making decisions. Then those decisions were reviewed by our Office of Management and Budget.

I would be happy to provide those to you.

[The information follows:]

EXCEPTED PERSONNEL

Secretary SHALALA. First of all, we do not refer to the employees who worked during the shutdown as "essential" and those who were furloughed as "nonessential." All our employees are essential. "Excepted" employees were determined to be performing functions based on legal exceptions to the Anti-Deficiency Act prohibitions against permitting employees to work in the absence of appropriations. These functions were either: (1) authorized by law, (2) necessary for the safety of human life, or (3) necessary for the protection of property. Therefore, the distinction is between those "excepted" and those that were not.

In our initial plan submitted to OMB on September 5, 1995, we determined that 25.5 thousand HHS employees (out of approximately 60 thousand) would be excepted. At the time of the November and December shutdowns, however, our estimates were 23.6 thousand and 24.2 thousand, respectively.

Mr. DICKEY. Did you ever make a dollar value as to what effect those non-essential employees would have on the budget?

Secretary SHALALA. I am not sure I understand the question?

Mr. DICKEY. I can understand that. It is kind of confusing.

Did you ever total up the total salary of those non-essential employees?

Secretary SHALALA. No, not that I know of. We certainly could do it.

If you think of what we had to do, most of the programs of the Department did not have their employees to perform oversight functions on nursing homes, sending out checks for Head Start, our responsibilities on Low-Income Home Energy Assistance—the welfare programs, Medicare—at one point we weren't paying our contractors who reimburse the hospitals and the doctors.

I would be happy to calculate those salaries.

Mr. DICKEY. I don't need to know the amounts, but I would like to know the titles, if you could do that for me.

Secretary SHALALA. Sure.

[The information follows:]

JOB CLASSIFICATION

Secretary SHALALA. Since our classification of employees during the shutdown was based on the functions they performed and whether those functions were either au-

thorized by law, necessary for the safety of human life, or necessary for the protection of property; we did not classify employees by title. As long as an employee met the definition of one of the legal exceptions, that person was considered "excepted," regardless of title. The following activities/functions were used to determine who would be excepted and who would be furloughed:

1. Activities having financing that is free of problem of lack of appropriations.
2. Operation of activities required to insure payment of entitlements.
3. Services of the Public Health Service Commissioned Corps.
4. Services of officers holding offices established by law.
5. Law enforcement activities.
6. Activities in support of Excepted Activities.
7. Direct health care activities (excluding the PHS Commissioned Corps).
8. Activities involving imminent threat to safety of human life (excluding direct health care).
9. Activities involving imminent threat to protection of property.

Mr. DICKEY. Thank you, Mr. Chairman.

PROGRAM CONSOLIDATION

Mr. PORTER. Thank you, Mr. Dickey.

That completes round one. We will go to round two. There are five of us here, plus Mr. Bonilla will be back, he tells me. Let's go on the 4-minute rule, which will take us up to 12:00.

Madam Secretary, how many program eliminations does your budget suggest?

Secretary SHALALA. I think it is 100 program consolidations and eliminations.

Mr. PORTER. Is that from 1996 projected?

Secretary SHALALA. The 1996 carries over into 1997.

Mr. PORTER. I don't know what that means.

Secretary SHALALA. That means that we identified it in 1996 and we are carrying over the same numbers into 1997. That is part of our long-range strategy.

Mr. PORTER. Would these be the same ones that we may have already eliminated in the fiscal year 1996 bill?

Secretary SHALALA. Some of them, probably.

Mr. PORTER. What new ones are you suggesting that we haven't eliminated previously or proposed to eliminate?

Secretary SHALALA. I think that everything is in the consolidations we have recommended. We would have to go back through and take a look at what you're actually doing in the fiscal year 1996 budget and then tell you what is in and what is out in terms of what we recommended and what the committee is continuing.

[The information follows:]

STREAMLINING

Secretary Shalala: In our FY 1996 budget request we proposed consolidating 116 programs into 19. The FY 1996 proposal was not enacted into law and in our FY 1997 budget we are also requesting program consolidations. We have refined our previous proposal and the FY 1997 budget proposes consolidating 110 programs into 19 and eliminates 6 small, categorical community services grant programs. This effort continues our commitment to strengthen partnerships with States, reduce the number of small, categorical programs, simplify grant application procedures and gain more flexible funding mechanisms.

In HRSA, 42 programs will be consolidated into 7 clusters. In FY 1996, we also proposed clusters for Rural Health and Emergency Medical Services. Because Congress eliminated direct funding for State Offices of Rural Health and Trauma Care, we no longer need to cluster these activities.

In CDC, 32 programs will be consolidated into 4 Performance Partnership Grants (PPGs). The only change from the FY 1996 proposal is that the HIV/STD/TB PPG has been split into separate HIV and STD/TB performance partnerships. Since HIV is still evolving as a disease with changing patterns of infection among different populations a separate partnership will be beneficial.

In SAMHSA, 23 programs will be consolidated into 4 programs. The FY 1997 proposal is similar to what was proposed in FY 1996 except that one program has been phased out and two others are no longer included in the current consolidation plans. Specifically, the Treatment Capacity Program has been phased out and no longer needs to be merged. The Children's Mental Health Program and the Protection and Advocacy (P&A) Program will remain separate programs.

In ACF, 13 programs will be consolidated into 4 programs. Due to the tight budget constraints we face this year and the concerns of the Congress to reduce the number of small, categorical grant programs 6 community services programs will not be funded. Programs to be eliminated are: National Youth Sports, Demonstration Partnership Program, Rural Community Facilities, Community Economic Development, Community Services for the Homeless and Community Food and Nutrition. These eliminations are not meant to take away benefits from any particular group, but to address the deficit in a manner that provides maximum flexibility to States and local communities in serving low-income individuals.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Consolidated HRSA Programs

Health Professions Clusters Consolidates 33 programs into 5 programs

Health Professions Workforce

Development (\$117.2 M)

National Health Service Corps Field Operations
National Health Service Corps Recruitment
Community Based Scholarships
Nursing Loan Repayment
Health Professions Data Systems
Research on Health Professions Data Systems

Enhanced Area Health Education Training (\$35.0 M)

Area Health Education Centers
Health Education and Training Centers
General Dentistry Training
Allied Health Special Projects
Geriatric Education Centers
Rural Health Interdisciplinary Training
Podiatric Medicine
Chiropractic Demonstrations

Nursing Education/Practice Initiatives (\$70.0 M)

Advanced Nurse Education
Nurse Practitioner/Midwife
Nursing Special Projects
Disadvantaged Nursing
Professional Nurse Traineeships
Nurse Anesthetist Training

Primary Care Medicine & Public

Health Training (\$80.0 M)

Family Medicine
General Medicine/Pediatrics
Physicians Assistants
Pacific Basin Medical Officer Training
Public Health/Preventive Medicine Programs
Health Administration Traineeships

Minority/Disadvantaged (\$64.1 M)

Centers for Excellence
Health Careers Opportunity
Exceptional Financial Need Scholarships
Loan Repayment for Faculty
Financial Assistance for Disadvantaged Health
Professionals
Loans for Disadvantaged Students
Scholarships for Disadvantaged Students

Health Services Clusters Consolidates 9 programs into 2 programs

Health Centers (\$757.1 M)

Community Health Centers
Migrant Health Centers
Health Care for the Homeless
Health Care for Residents of Public Housing

Programs for Special Populations (\$7.4 M)

Black Lung
Alzheimer's Disease Demonstrations
Pacific Basin
Payment to Hawaii
Native Hawaiian Health Care

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Consolidated CDC Programs

Consolidates 32 programs into 4 programs

HIV Grant (Formula Grant)
11 Programs (\$297.9 M)

HIV/AIDS:
 Surveillance for HIV/AIDS Reporting Timeliness
 Other Ongoing Surveillance Activities
 IDU-Health Education/Risk Reduction
 Other Health Education/Risk Reduction
 IDU-Counseling, Testing, Partner Notification
 Other-Counseling, Testing, Partner Notification
 HIV Prevention Among Drug Users
 Public Information
 State and Local Minority Initiative
 Direct Funding of Minority Community-Based Organizations
 Women's & Infants Perinatal AIDS Reporting

STD/TB Grant (Formula Grant)
9 Programs (\$182.3 M)

Sexually - Transmitted Diseases:
 Prevention and Control
 Infertility Prevention
 Surveillance/Monitoring Disease Trends
 STD Accelerated Prevention Campaign
 TB/HIV

Tuberculosis:
 Prevention Control and Elimination
 Surveillance Assessment
 Research Demonstration
 TB Laboratory Capacity

Chronic Disease and Disability Grant
(Formula Grant) 6 Programs (\$117.4 M)

Behavioral Risk Factor Surveillance (BRFS)
 Cancer Registries
 Diabetes
 Disabilities
 Breast and Cervical Cancer
 Tobacco

Immunization Grant
(Formula Grant) 6 Programs (\$176.7 M)

State Operations
 Parent/Patient Notification
 Surveillance and Response
 Infrastructure
 Program-Based Incentives
 National & State Specific Immunization Level
 Assessment

**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN.
(SAMHSA)**

Consolidated SAMHSA Demonstrations/Block Grants

Consolidates 23 programs into 4 programs

**Consolidated Substance Abuse Knowledge
Development and Application
(15 Programs) \$352 million**

Pregnant Woman and Infants
Community Prevention
Target Cities
High Risk Youth
AIDS Linkage
AIDS Outreach
Critical Populations
Treatment Improvement
Pregnant/Postpartum Women
Substance Abuse Prevention Training
Addiction Treatment Training/AIDS Training
Public Education and Dissemination Program
Program Contract/Campus Project
Criminal Justice Program
Comp. Community Treatment Programs

**Substance Abuse Performance Partnership
(1 Program) \$1.3 billion**

Substance Abuse Block Grant

**Mental Health Performance Partnership
(2 Programs) \$275 million**

PATH Formula
Mental Health Block Grant

**Consolidated Mental Health Knowledge Development
and Application (5 programs) \$62 million**

Community Support Program
Prevention Demonstrations
Homeless Demonstrations
AIDS Demonstrations
Clinical and AIDS Training

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

Consolidated ACF Programs

Consolidates 13 into 4 Programs

Child Welfare Innovative Programs **4 Programs (\$39.2 M)**

Child Welfare Research and Demonstration
Child Welfare Training
CAPTA Discretionary
Grant
Adoption Opportunities

Child Care & Development Block Grant **3 Programs (\$934.6 M)**

Child Care and Development Block Grant
Child Development Associate Scholarships
Dependent Care Planning & Development

Comprehensive Runaway and Homeless Youth **3 Programs (\$68.6 M)**

Runaway and Homeless Youth
Transitional Living and Homeless Youth
Drug Education & Prevention for Homeless Youth

Community-Based Resource Centers **3 Programs (\$50.6 M)**

Family Support Centers
Temporary Child Care and Crisis Nurseries
Community-Based Resource Centers

Mr. PORTER. We realize that the department itself is not responsible for the proliferation of programs. It is usually the Congress that is doing that. But we also recognize that at some point in time we have to get back to core programs and eliminate the smaller higher-overhead ones and try to make the administration of what you do, therefore, more efficient. That is why we are anxious to look at that.

I have to say that I have been disappointed in the Administration's budget, not from the standpoint that it doesn't identify high priorities and support them, but from the standpoint that it really front-loads spending increases. You are asking for an overall increase of about 5 percent for the next fiscal year. It does not give us any real help. It gives us some help, but not any real substantial help as to where we are going to find the savings to really bring the budget into balance over the next period of time.

I frankly think, Madam Secretary, from the standpoint of saying that we can take Medicare and Medicaid and find savings only through providers—which is what we have been doing for years—and bring down the rate of increase in those programs without asking to slow the rate of spending and therefore provide somewhat more in the way of participation from those at least who can afford it, I think we are simply not being realistic about it at all.

Quite frankly, I believe—and I will predict sitting here—that if President Clinton is reelected in the fall, he will come back with suggestions about restraints in the rate of increase in the entitlement programs that aren't very different from the ones we have suggested in this Congress to date. I think all of us realize that these things have to be accomplished. If we are ever to bring the budget into balance, we have to restrain the rate of increase in the programs.

There is no real way to do that without asking contribution from all the people in our society. I don't think we can shift burdens any longer. We have had a Health Care Financing Administration that has spent the last 10 years shaving the edges and pushing more and more onto providers, who then try to shift it to other places. I think that basically has reached a dead-end and there is no real way that we can continue to say that that is going to solve our problems.

I think it is time for a little more encouragement and a little less politics. But I am afraid that is going to have to wait until after the election.

That was not a question, but rather a statement—as you noticed. [Laughter.]

Secretary SHALALA. I appreciate that.

WASTE, FRAUD AND ABUSE

Mr. PORTER. Let's talk about waste, fraud, and abuse for a moment because you and I discussed it earlier.

Why does this new effort you have described have to be a mandatory account rather than a discretionary account? What does that mean to oversight?

Secretary SHALALA. First of all, we are available for oversight any time any committee of Congress wants us to come up and report or the Inspector General, in this case, reports on the effective-

ness of our efforts to eliminate fraud and abuse from the entitlement programs.

Second, we were searching for a way to have a kind of steady funding and substantially increase our investment in our fraud efforts in the programs. It makes sense that the part of the program that is being investigated finance the waste and fraud activities. That is why we came up with the concept of doing it on the mandatory side.

Let me also point out that this concept has already been passed in the Republicans' own bills. It enjoys bipartisan support.

Mr. PORTER. Except from appropriators.

[Laughter.]

Secretary SHALALA. It seems to me that it is not appropriate for me to get involved in the jurisdictional issues. What is appropriate is for me to report to you that we believe strongly that this country must make additional investments—substantial investments, steady investments—in dealing with waste, fraud, and abuse. We started out using our authority on the mandatory side to demonstrate in the handful of States where there was intensive activity that we could put a program in place that would make a difference.

CBO estimates that we will get \$7 back for every \$1 we invest in that effort. We now would like to expand it nationwide. We would like to expand it with the same kind of financing mechanism that we have been demonstrating it with.

Mr. PORTER. Well, we would like to give you the tools you need to work with, but we wouldn't like to give up the oversight to see whether we are actually getting results. I think, frankly, the kind of proposal that was made yesterday on the House floor by Mr. Shuster to take away discretionary authority is exactly the kind of problem that we find ourselves in today with so much tied up in entitlements that we really don't have any substantial control over budgets, and therefore end up being irresponsible year after year after year.

We certainly want to work with you on this, but the mandatory part I think really doesn't work.

Mr. Obey?

Mr. OBEY. Thank you, Mr. Chairman.

I would suggest that the next time—God forbid—we have a Government show-down in addition to the Executive Branch having to answer questions about which officials it has considered essential that the Administration consider asking Congress which Members of Congress it regards as essential during a Government shut-down as well. [Laughter.]

MEDICARE

With respect to the question offered by Mr. Miller, I do believe that the long-term goal of the Republican Party leadership is to end Medicare as we know it. When you recognize the fact that 90 percent of Medicare beneficiaries cost less than \$1,300 a year whereas 10 percent cost \$28,000 to the system, when you recognize that with the establishment of the medical savings accounts you give a tremendous incentive for those people who think they are going to be the healthiest to opt into those, when you see the fact that the look-back provision in case Medicare did not achieve the

cost savings expected would fall only on traditional Medicare programs, when you see that with the alternative provider-sponsored networks which would have been allowed in their suggestions, when you see that those propositions would allow a billing above the normal billing allowed in Medicare, you bet we think it would destroy Medicare as we know it.

Madam Secretary, I have no questions. I just have one additional observation.

BUDGET REDUCTIONS

The reason a lot of people like myself are not comfortable with cutting some of the programs in your budget as deeply as has been suggested by people up here is because we think people are having a fundamental misreading of what has been occurring in this economy for over 20 years. We seem to have the attitude that just because unemployment is hovering around 6 percent that lots of people are doing well and therefore don't have to provide essential services to a lot of people.

Let me point out what the numbers are. You have 7.5 million unemployed. You have 5 million to 6 million who are not counted as being unemployed, even though they are. You have 4.5 million part-time workers in the economy. You have 8.1 million temporary workers. You have 2 million more workers who are employed on-call only. You have over 8 million people who call themselves independent contractors, but who really are virtually unemployed and who simply, because of pride, don't want to call themselves that. You have 5.8 million people in the economy who show up in the census rolls that do not show up in any of the labor markets.

When you put it all together, that means you have about one-third of the people in this country who want to be working more than they are able to work right now. That means that there are lots of families who may not be officially on rolls that are readily recognized as needing help, but who nonetheless do need help.

When we focus reductions on the programs that essentially deal with the economic half of our society that is on the low-end—when they lose their job, it is not like the CEO who is paid 179 times as much as the average worker in his corporation. It is a little tougher to get over that next month when you don't have paychecks coming in, or when the pay checks are skinnier than you expected or need, and when you have kids trying to go to college and other problems in the family as well.

I don't think you need to apologize for the budget request that you have come up with here. In my view, in many cases we are short-changing people who need help the most. I hope you stick to your guns until we get a rational allocation of resources in this country.

Thank you.

Mr. PORTER. Thank you, Mr. Obey.

Mr. Miller?

MEDICARE

Mr. MILLER. I have just one question, but I will make a brief comment first about Medicare.

I am disappointed with the partisan belief that scare tactics are right for seniors. I have a lot of seniors in my district. There were a series of town meetings in my district last week. Seniors want to contribute to solving the problem. Seniors have asked me, "If Medicare is going bankrupt, why did you cut my premium?"

My answer is, "Presidential politics."

That is too bad. We need to solve the problem. It shouldn't be a partisan issue. I have an 87-year-old mother on Medicare. I am sure you have relatives and friends on Medicare. We all have to preserve it.

During the debate for reforming health care, you all were talking about 6 to 7 percent relative rates in health care spending—we are at 7.1 percent in Medicare—and talking about having a system that is similar to what we as Members of Congress have available. We get to choose, so why not give seniors the right to choose?

I am disappointed in the partisanship, but let me ask my question.

President Clinton in his State of the Union speech said that the era of big Government is over. How does that relate to you and your department?

STREAMLINING

Secretary SHALALA. Actually, in the last year we have cut over 3,000 jobs. The number of employees in the Department is coming down rapidly. We are doing more with less people. And the growth of the Department in the non-priority areas has slowed down considerably.

We have done exactly what the President is talking about: significantly reduced the number of employees, streamlined the management of the Department, and have gone into joint partnerships with the States. We are moving to performance partnerships as opposed to the more categorical, narrower, heavily regulated kinds of approaches.

As the President pointed out, we will have fewer government employees than at any time since the Kennedy Administration.

Mr. MILLER. Do you have less employees this coming year than you had?

Secretary SHALALA. Yes, absolutely.

And we will meet our goals. In fact, we have moved so rapidly that we will probably meet our goals a couple of years earlier than what is in the President's budget.

PROGRAM CONSOLIDATION

Mr. MILLER. I think last year when I was here I asked how many programs you proposed to eliminate.

Secretary SHALALA. We are consolidating 100.

Mr. MILLER. The Appropriations Committee did a lot of that.

I think we have to go vote. Mr. Chairman, I am going to go vote, too. I yield back my time.

SURGEON GENERAL

Mr. BONILLA [assuming chair]. I have just a couple of follow-up questions to the lighter questioning I had before about the Surgeon General.

You said in one of your answers that no nominee was obvious. Did that mean that it is difficult to find someone who could obviously be nominated, or obviously it would be difficult?

Secretary SHALALA. I think I said that the politics were obvious. We have had bitter politics over the President's nominees. He has made a decision to wait until after he is reelected to make a nomination. We have a person acting in that position who is performing extremely well so that the office is operating. We have major reports coming out. The prevention activities as well as the supervision of the Commissioned Corps are functions in the Department and the Surgeon General's role, in our judgment, continues to be very important.

Mr. BONILLA. One thing I wanted to emphasize was my motivation for my questioning along this line. Last year, the language in the bill that tried to eliminate funding for the Surgeon General was a non-partisan effort. I have never been one who has been critical of either the former Surgeons General or the nominees that were controversial in the last couple of years. My concern was strictly one of fiscal interest and whether or not the position is duplicative. As I alluded to in my first round of questions, considering whether you or Dr. Satcher could be considered for filling that role.

I think you have done very well, as I said in the beginning. I just wanted to state that for the record.

OFFICE OF PUBLIC HEALTH AND SCIENCE

I would like to ask a couple of questions about the Office of Public Health and Science.

You are proposing a staffing level of 305 FTEs, including 57 reimbursable FTEs, for the Office of Public Health and Science, including 36 for the immediate Office of the Assistant Secretary for Health. Why is it necessary to have 305 people in this office? Why couldn't this area be trimmed back?

Secretary SHALALA. We have trimmed it back considerably. We have eliminated literally hundreds of jobs from the Office of the Assistant Secretary for Health, doing exactly what you indicated we ought to do in your comments about the Surgeon General, merging overlapping budget and administrative functions. What is left is program offices: the Office of Women's Health, the Office of Minority Health—that is where the big numbers are in the Office of the Assistant Secretary for Health.

The Assistant Secretary for Health continues to be the senior coordinator on public health and we have left some staff jobs there, but 1,200 jobs have been eliminated in that office. That is a major reduction. What is left is what we consider essential.

Mr. BONILLA. How is the job of the Assistant Secretary for Health changed since the old OASH was abolished last year?

Secretary SHALALA. We didn't abolish it. The Assistant Secretary for Health will continue as an Assistant Secretary for Health. What we did was eliminate the duplicative budget functions and adminis-

trative functions in that office—which adds an extra administrative level above the NIH, the FDA, and the CDC—we have flattened out the administration. The Assistant Secretary for Health will continue to be the senior public health official in the Government and coordinate public health activities.

Let me give you an example. When we are dealing with something like emerging and re-emerging diseases—TB, for example, which has popped its head again—we need coordination between the National Institutes of Health, the CDC, the FDA, and a number of other health organizations. It is the Assistant Secretary of Health that convenes those cross-cutting activities. The Ebola virus, “Mad Cow Disease”—are other issues coordinated by the Assistant Secretary for Health. The development of our tobacco-free initiative for kids is coordinated by the Assistant Secretary for Health.

The major public health issues—the changing of this country’s interest from just acute care to prevention is led by the Assistant Secretary for Health. It is a critical function. We have eliminated the duplication. No one has ever walked in here before now and said that they have eliminated 1,200 jobs, all the duplications, keeping the core functions, but have kept the leadership function of that person.

Mr. BONILLA. Madam Secretary, thank you.

I am going to have to return to my office for an appointment that I have there. Mr. Riggs will return momentarily. If you will be patient with us, it takes about 6.5 minutes to walk to the Capitol to vote and about 6.5 minutes to walk back. He should be back momentarily. Thank you for your patience.

[Recess.]

Mr. RIGGS [assuming chair]. I will call the subcommittee back to order and apologize for us coming in and out in shifts.

I have some quick questions that I would like to run through. Then I am informed that Ms. Lowey is going to return and will have a couple of additional questions to ask. Then we will conclude this morning’s hearing and stand in recess until the afternoon hearing.

EMERGENCY ASSISTANCE FUNDS (EA)

Madam Secretary, I would like to focus in for just a moment on the department’s decision to terminate the Title IV(a) Emergency Assistance Funding. I would like to know how the department or the agency involved came to the conclusion that it no longer needed to fulfill contractual obligations under AFDC emergency assistance, Title IV(a), that it provided to States so that States in turn could provide services within their juvenile justice systems.

I am familiar with this program in California and I can assure you that the funds have been well spent to make community placements of both status and juvenile offenders in foster homes and group homes.

Can you reconcile the fact that Federal law allows each State to define what they consider emergency situations, as long as that definition is consistent with the intent of the law, but the consequent denial of funding to those States, even though they feel their definitions are consistent with the intent of the original law?

Secretary SHALALA. We do not believe that was the intent of the original law. We notified the States with plenty of months in advance. The EA program has been growing rapidly. In fact, the major growth in welfare in this country is not AFDC, but the Emergency Assistance Program. Some States have begun to shovel what were actually State costs for their juvenile justice system into the Emergency Assistance Program, which has been driving up the cost of the Emergency Assistance Program.

We do not believe it was a congressional intent of this program that States were to shift huge costs—and we are talking about major costs. For example, if juvenile justice systems were allowed to be financed under the Emergency Assistance Program under an amendment that you have introduced, we would increase the cost to the Federal Government between \$300 million and \$500 million. These are not small costs. If Congress intends that juvenile justice systems should be covered and that the Emergency Assistance Program is now to be used to shift what we believe are obvious State costs into an emergency program, then it should take affirmative action to spend \$300 million to \$500 million for that purpose as opposed to finding a softness in a program that was clearly designed for short-term emergencies and using that as a way of shifting State costs.

We have very serious concerns about suddenly ballooning up a program by \$300 million to \$500 million, particularly in this era of us trying to reduce the cost of programs, by running up costs through the emergency assistance program.

We notified the States with plenty of advance notice that they would no longer be allowed to do this. We do not believe that they should be allowed to do this without a direct full discussion by Congress that this is a new program that they now would like to assume the cost of.

Mr. RIGGS. How much notice did you give the States?

Secretary SHALALA. We gave them notice in September that by January they were no longer to include juvenile justice programs.

Mr. RIGGS. Was there a reason for terminating the funding in mid-fiscal year?

Secretary SHALALA. Yes, a deep concern on our part that this was an inappropriate use and that I would have to answer to oversight committees on why we were allowing the Emergency Assistance Program to be radically changed in terms of our projections of what its cost would be. We think that was adequate notice for the States.

Mr. RIGGS. Madam Secretary, I know you are on a tight schedule and we have run past noon. My colleagues have additional questions, so I am going to withhold my questions and submit them for the record.

Secretary SHALALA. I will be happy to answer them for the record.

Mr. RIGGS. I look forward to your written responses.

Ms. Lowey?

PERFORMANCE PARTNERSHIP

Ms. LOWEY. Thank you, Mr. Chairman.

I thank you for your responses.

I have one quick statement to my colleague and good friend, Mr. Dickey, that in my talking to Dr. Klausner of the National Institutes of Health National Cancer Institute about 10 days ago—he told me that while the Government was shut down, six cancer drugs were delayed. I think when we talk about essential and non-essential, we really have to be very careful. I don't think the entire implications of the Government shut-down are really known to us.

I wanted to follow-up, Madam Secretary, on the question that my colleague, Ms. Pelosi, asked concerning the CDC prevention programs.

I agree that flexibility is an appropriate goal in numerous instances. I continue to be concerned, as I was last year, about the Administration's proposal to block grant the breast and cervical cancer screening program to the States.

Under the budget request, it appears that the program would be block granted along with the chronic and environmental disease prevention program, and the total amount of these programs will be cut by \$4 million. Should we block grant a program to the State when all States don't have programs? Likewise, there are certain program standards States now have to meet in order to receive Federal funding. These standards are vital to the quality of the program.

I am also concerned, for similar reasons, about the consolidation of the HIV, STD, and TB programs. How can we ensure that under your consolidation proposal we don't lose services, particularly breast and cervical cancer screening?

Secretary SHALALA. First of all, we are not block granting those programs. We believe that there is a difference between performance partnerships in which we agree on the outcomes with the States, and they agree that they will take advantage of the flexibility to meet those outcomes. Proper oversight and modern management demands that we shift from measuring inputs as opposed to outcomes. We are trying to move to a different relationship with the States.

I realize that it is somewhat controversial and that those who have spent so much time making sure we have the resources for these particular programs are uncomfortable as we move away from narrower categorical approaches. We will have the same kind of firm oversight to produce what we hope would be better outcomes and better coordination of a variety of different programs.

We now have a new center at the CDC which focuses on STDs and AIDS. The new face of who has these diseases in this country means that we have to attack these diseases and those who are unfortunate to get them from a number of different directions. This interrelationship requires coordination and therefore is not inappropriate. Again, the money is put out in a performance partnership, which is a tough new kind of way to measure outcomes as opposed to measuring process and inputs.

WASTE, FRAUD AND ABUSE

Ms. LOWEY. I just want to say that I particularly applaud your crackdown on waste, fraud, and abuse in Medicare. In fact, during the 1980s, most of these problems were swept under the rug under another Administration. In fact, the people in New York tell me

that there has been extraordinary cooperation with your agency. This partnership is also critical in cracking down. I believe it is almost 10 percent of the dollars that are saved.

I just want to thank you in your efforts. Keep it up so that we can restore confidence.

Secretary SHALALA. I appreciate that.

Let me simply repeat. Again, this is a partnership between local law enforcement officials, U.S. attorneys, the FBI, the Justice Department, and our own Inspector General Office. That is why there is so much enthusiasm at the State and local level for these efforts at waste, fraud, and abuse. They really are partnerships in the major States in this demonstration. We really do want to expand it across the country.

Mr. RIGGS. Thank you, Ms. Lowey.

Mr. Dickey?

AIDS RESEARCH

Mr. DICKEY. Thank you, Mr. Chairman.

Madam Secretary, This question is a follow-up to a previous question. I want you to know that I voted for the AIDS appropriations. I followed Chairman Riggs' example the first time and I have since then.

I heard the response that funding determinations for research projects are made scientifically and depending upon where the opportunities lie. I don't think we have run out of cancer research opportunities. Can you tell me the percentage of research requests that are accepted and denied for cancer and AIDS?

Secretary SHALALA. I will provide them for the record. I don't have them with me.

[The information follows:]

AIDS AND CANCER RESEARCH FUNDING

Secretary Shalala: NIH uses success rates for research project grants (RPGs) to express the likelihood that a competing RPG application will "succeed" in being awarded. Success rates are calculated by dividing the number of competing awards by the total number of competing RPG applications received. Grant applications are assigned to the various NIH institutes for potential funding by matching the mission of institutes and centers to the research proposed in each application. Selections for funding are based on scientific merit as reflected by peer review. Success rates reflect the likelihood that an application will be awarded out of a specific institute's appropriation or by NIH overall, but in general they do not reflect the likelihood that research on a particular disease or area of research will be funded.

For several years, NIH has identified success rates for grants funded through AIDS budgets. For most Institutes and Centers (ICs), AIDS grants constitute a very small portion of the competing research project grant (RPG) portfolio. Numbers of grants are not statistically significant which makes calculating meaningful success rates difficult. With the exception of the National Institute of Allergy and Infectious Diseases (NIAID) which funds 43 percent of NIH-supported AIDS research, IC success rates for AIDS competing RPGs are the same as for total competing RPGs. Overall, AIDS success rates are 27 percent in FY 1995, 24 percent in FY 1996, and 23 percent in FY 1997. AIDS success rates for NIAID are 40 percent in FY 1995, 22 percent in FY 1996, and 24 percent in FY 1997. Success rates for the National Cancer Institute (NCI), which supports 90 percent of cancer research at the NIH, provide a reasonable approximation of cancer success rates for NIH as a whole. Success rates for the NCI are 26 percent in FY 1995, 26 percent in FY 1996, and 22 percent in FY 1997.

A fuller display of the success rates for the entire NIH is presented in the following table, which can be found on page 55 of Volume I of the NIH Congressional Justifications.

Success rates for individual institutes and centers will vary from year to year as a function of total availability of funds, noncompeting commitments from previous years' competing grants, and numbers of grant applications.

NATIONAL INSTITUTES OF HEALTH
Research Project Grants
Success Rates
FY 1988 - 1997

INSTITUTE	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994 Comp.	FY 1994 Reallocated	FY 1995 Bud. Auth.	FY 1996 Estimate	FY 1997 Estimate
NCI	33%	25%	24%	28%	32%	25%	22%	22%	26%	26%	22%
NHLBI	31%	26%	25%	28%	29%	22%	27%	23%	27%	22%	23%
NIDR	25%	23%	21%	30%	27%	24%	31%	37%	29%	22%	24%
NIDDK	32%	26%	23%	27%	33%	22%	22%	25%	27%	19%	25%
NINDS	40%	32%	24%	30%	27%	25%	22%	26%	31%	23%	23%
NIAID	31%	30%	27%	31%	30%	29%	27%	25%	25%	25%	22%
NIGMS	39%	28%	22%	34%	36%	30%	29%	33%	39%	35%	31%
NICHD	25%	24%	19%	25%	26%	21%	21%	21%	18%	17%	17%
NEI	43%	43%	38%	33%	31%	32%	31%	40%	36%	35%	39%
NIEHS	29%	26%	28%	28%	28%	21%	21%	26%	16%	22%	25%
NIA	25%	23%	21%	30%	29%	23%	25%	25%	29%	33%	28%
NIAMS	26%	26%	20%	31%	18%	21%	19%	20%	24%	24%	22%
NIDCD	40%	38%	37%	31%	30%	29%	28%	32%	34%	29%	29%
NIMH	29%	29%	24%	27%	27%	20%	27%	21%	19%	17%	18%
NIDA	19%	38%	37%	31%	31%	32%	31%	33%	30%	23%	23%
NIAAA	27%	38%	34%	23%	32%	19%	30%	29%	22%	18%	15%
NINR	27%	19%	16%	19%	15%	11%	11%	12%	32%	21%	27%
NCRR	0%	0%	22%	29%	33%	28%	27%	18%	23%	46%	49%
NCHGR	0%	0%	23%	38%	22%	28%	17%	28%	26%	28%	33%
FIC	0%	0%	0%	0%	0%	0%	6%	27%	65%	32%	28%
NIH	31%	28%	25%	29%	30%	25%	25%	25%	27%	24%	23%

Mr. DICKEY. Thank you.

Secretary SHALALA. But in general, as you well know, even though this Congress, in a bipartisan fashion, has made substantial increases in the National Institutes of Health, we have not been able to fund all the research projects we have wanted to fund in a number of different areas related to major strategies, whether cancer or AIDS or mental health. I would not be surprised if there were a gap between the two.

SURGEON GENERAL

Mr. DICKEY. I have one last question, and I think you have a right not to answer this if you don't want to.

Do you think that a person who is pro-life is not qualified as a Surgeon General?

Secretary SHALALA. I do not.

Mr. DICKEY. You think they are qualified?

Secretary SHALALA. I think that question is up to a President of the United States. This President, who is pro-life and pro-choice, who believes that it is a woman's right to choose, has made his choice of Surgeons General on a number of different criteria. I think every President has the right to determine what the qualifications are of a Surgeon General. That is a presidential decision.

Mr. DICKEY. But I am asking your opinion.

Secretary SHALALA. My opinion is consistent with the President's. I believe that the Surgeon General candidate ought to have views which are consistent with the President's. This President and this Secretary of HHS are firmly defenders of a woman's right to choose and reproductive rights.

MEDICARE TRUST FUNDS

Mr. RIGGS. Madam Secretary, we very much appreciate your testimony. I realize it is 12:10 and you had to leave at 12:10. I just want to exercise the chairman's prerogative and ask you one other question. This probably came up in your earlier testimony. If it did, forgive me, but I wanted to just state for the record what you obviously know quite well.

A year ago this month, Medicare trustees—yourself included—issued a report to the Congress. Of course, we now realize that we ended 1995 with the first annual deficit to the Medicare Trust Fund in 22 years. In view of your report a year ago, and in view of the year-end deficit, what is your current thinking in terms of the cost-savings necessary to protect Medicare from bankruptcy?

Secretary SHALALA. Technically, we didn't end with a deficit because there were reserves. Clearly, we are putting out more money than we are taking in. But because there were reserves, there was not an actual deficit. The actuaries were off by a few months—maybe as much as a year. We will see in the next report that findings reported to Congress do not change the conclusions of the trustees. This Congress must deal with the issue of the Medicare Trust Fund as quickly as possible.

The President has submitted a budget which does that. There are Republican budgets which extend life of the Trust Fund at the same time. We are arguing over the policies within those budgets.

All of us have proposals that extend the life of the Trust Fund by about another 10 years.

In addition to that, we need to do some long-term planning for the Medicare Trust Fund.

So I think the trustees' report—both the public and private trustees—will not dramatically change what has been very strong rhetoric about the need to deal with the Medicare Trust Fund.

Mr. RIGGS. Thank you, Madam Secretary.

[The following questions were submitted to be answered for the record:]

IMMUNIZATION

Mr. Porter: When the States were first surveyed for the VFC eligible population within their states, the original data they received was wildly inaccurate with some States estimating more than double their total child population. Has CDC requested that the States resubmit more accurate population profiles? If so, would you please provide them to this Committee so that we can have an accurate picture? If you have not ordered a new profile, why not?

Secretary Shalala: VFC is implemented by the States. The CDC has given each State considerable flexibility in determining how to manage key parts of their program. Vaccine accountability is a key part and is considered by CDC to be a primary responsibility of each State. CDC recognizes, however, that each State's circumstances are different and require each State to determine how best to assure that VFC vaccine is used solely for VFC eligible children.

When first gearing up for VFC implementation, States queried providers for estimates of children by eligibility category to develop State profiles. The results were then simply tallied and transmitted to CDC. We recognize the importance of fine tuning these estimates and CDC has requested that States, as they gain program experience, review profile information for accuracy to further enhance program effectiveness. On an annual basis, CDC collects and analyzes data from the States on the number of children to be served by VFC, as well as other funding sources. These aggregate data are consistent with the size of the birth cohort and CDC national and State analyses of vaccine purchase patterns indicate that VFC vaccine use is appropriate. We will be happy to provide the Committee with State profiles as they are updated.

Major progress has been accomplished in implementing the VFC program. In less than 1-1/2 years, a number of milestones have been achieved. Some include:

- ▶ Coverage - Vaccines For Children (VFC) guarantees coverage for all Advisory Committee on Immunization Practices (ACIP) recommended childhood vaccines, including Hepatitis B for adolescents and catch-up Measles, Mumps, Rubella-2 (MMR2).
- ▶ Improvement in VFC Provider Enrollment - Between October 1994 and November 1995, the number of provider sites (sites typically include a number of physicians) enrolled increased by about 80 percent, from about 20,000 to 36,000 sites.
- ▶ VFC Vaccine Delivery - As of March 1996, all States were delivering vaccine to the public sector, and 46 States, including Alaska, were delivering to the private sector.

- ▶ Savings for State Medicaid and public health programs - State public health programs are assured of purchasing vaccines at the CDC contract price, and State Medicaid programs have realized substantial savings. For example, California is reinvesting savings of about \$20 million a year to improve childhood immunization rates.
- ▶ Vaccine Purchase Contracts - For each of the past two years, about 18 vaccine contracts have been negotiated and signed with manufacturers to provide VFC vaccine at reduced contract prices for all vaccines routinely recommended for children.
- ▶ VFC Accountability - Recent national (e.g., conducted by CDC, and HCFA) and State analyses indicate VFC vaccine use is appropriate. Nationally, VFC spending is consistent with State estimates of the children who were to be served by VFC.
- ▶ Private/Public Sector Cooperation - Some studies report that the VFC program is reducing the referral of children away from their medical homes. For instance, New York reports a 51% decline in referrals. Also, significant progress has been made in building partnerships between the public and private sectors.

Mr. Porter: While the VFC has imposed low price caps on the purchase price of vaccine, some administration fees appear generous as compared to other government-funded immunization programs. For instance, in Maryland the State Medicaid program reimburses fee-for-service providers \$10 per dose while HCFA allows \$15.49 per dose--more than 50% more than the State program. Doesn't such a situation induce providers to use the Federal program or to bend the rules to use the higher payment rate?

Secretary Shalala: The Omnibus Budget Reconciliation Act of 1993 (OBRA) extended existing negotiated vaccine contract prices to a newly eligible cohort of uninsured, underinsured and Native American children. OBRA 93 also required that administration fee caps be established. The administration fee caps were initially established on "usual charge" data provided by the American Academy of Pediatrics because cost-based data did not exist. To develop such data, HCFA has undertaken a study to estimate actual provider costs and hopes to base future fee caps on these costs. The study should be completed in the summer of 1996. Also, the fee caps are maximums and do not necessarily reflect the actual charges being passed on to patients.

Under the VFC program, the administration fee for many parents may be waived or reduced. Physicians who receive publicly purchased vaccine cannot deny immunizations because of a parent's inability to pay a vaccine administration fee.

Mr. Porter: If you are looking to reduce costs of the VFC program, what are you doing to reduce the cost component that is escalating administration?

Secretary Shalala: The VFC program has already proven to be cost effective for State taxpayers. Before VFC, State Medicaid programs reimbursed providers for vaccine acquired at much higher commercial prices. The CDC negotiated contract price for the full series of vaccines is \$164 compared to the commercial price of \$313. Purchasing Medicaid vaccine from the CDC contracts has allowed States to realize substantial Medicaid savings. California is reinvesting savings of about \$20 million a year to improve childhood immunization rates. Michigan has freed-up several million dollars in State funding for other important activities.

Mr. Porter: The vaccine manufacturers and many of us in Congress are concerned that the VFC program is hurting industry research and development efforts because the private market for vaccines is shrinking dramatically under VFC. Have you completed the assessment requested by the National Vaccine Advisory Committee in this area? What is the status of that study?

Secretary Shalala: The National Vaccine Program Office, part of the U. S. Public Health Service (PHS), entered into, and was responsible for, a contract with Mercer Management Consulting, Inc. (Mercer) in response to the National Vaccine Advisory Committee's (NVAC) June, 1994, resolution. This resolution called for the Secretary to "require a thorough analysis, as soon after October 1, 1994 as reliable data are available, of the effect on the statutory price limitation on research and development for new and improved vaccines." The purpose of the contract with Mercer was to develop an understanding of the economics of the United States vaccine industry and an accurate picture of the effect of the OBRA 1993 legislation on U.S. manufacturers.

Mercer presented their final report to NVAC at the May 1995 meeting. Despite its best efforts, Mercer was unable to obtain data from vaccine manufacturers about the manufacturers' research and development activities, including costs. Without such critical data, Mercer could not make an independent quantitative assessment of the effect of OBRA 1993 on the companies. Since these data were not available to accurately assess the impact on research and development, further study could not be undertaken.

It is important to note that vaccine manufacturers are free to negotiate prices without a price cap on vaccines introduced after May 1993 (DTP/Hib, Hepatitis A, Varicella, and Hepatitis B-Adolescent) and also to negotiate the maximum amounts to be purchased off federal vaccine contracts. Thus, companies can factor in research and development costs in these negotiations.

Mr. Porter: Have you met with the manufacturers to discuss the issue?

Secretary Shalala: The Assistant Secretary for Health has contacted vaccine manufacturers about obtaining essential information about manufacturers' research and development activities. After Mercer was unable to obtain this essential data, the Assistant Secretary for Health wrote to the vaccine manufacturers in an attempt to obtain this critical data. The Assistant Secretary offered to work with the manufacturers to determine a method by which data could be shared to fairly assess the impact of current vaccine purchase practices on vaccine research and development efforts. After sending this letter, the Assistant Secretary for Health called each manufacturer to further explore this matter. However, no access to this essential information was provided.

Vaccine manufacturers are key partners in helping assure that children are safe from vaccine-preventable diseases. Representatives from the vaccine manufacturers are members of the NVAC and ACIP and actively participate in meetings, subcommittee activities and discussions. Participation has included specific discussions in the area of vaccine development and research. In addition, at the recent 30th National Immunization Conference, Dr. Gordon Douglas, Jr., M.D., President, Merck Vaccines, Merck & Co, Inc., presented a number of proposals to discuss the future of research and development and other important issues. We will continue to foster these partnerships to help preserve and expand our nation's vaccine manufacturing and research capacity.

Mr. Porter: I have heard that a proposal is being considered by your department to have a national distribution contract for VFC. What is the legal authority for this?

Secretary Shalala: The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) requires the Secretary to both purchase vaccine for administration to Federally vaccine-eligible children and to provide for its delivery. Specifically, section 1928(a)(2)(A) of the Social Security Act mandates that "the Secretary shall provide...for the purchase and delivery [of VFC vaccines] on behalf of each State..., without charge to the State." With the mandate to provide for the delivery of the vaccine, the Secretary is given the discretion of choosing the method for delivery of the vaccine.

VFC vaccine is being delivered to virtually every provider who would like to receive it. Currently, all States are delivering VFC vaccine to enrolled public sector providers (about one half of the vaccine used in the country). As of March 1996, 46 States were delivering VFC vaccine to enrolled private providers. Two additional States have signed contracts with commercial distribution companies. Even though vaccine delivery is now occurring, Indiana and New Jersey have asked CDC to provide a distribution mechanism in their States. The CDC plans to enter into a private sector distribution contract. When this contract is in place, a relatively small number of States (less than 10) are expected to choose to use this delivery option. Potential bidders for the delivery contract include vaccine manufacturers and commercial distributors.

Mr. Porter: Where is the money coming from?

Secretary Shalala: Funds for VFC vaccine delivery come from the VFC entitlement program, as directed by OBRA 93. Section 1928(a)(2)(A) of the Social Security Act outlines the obligation of the Federal Government to provide for the purchase and delivery to States of the vaccines for Federally vaccine-eligible children. When vaccines are purchased by States using Section 317 funds or other State funds, the costs associated with delivery of those vaccines are paid by the appropriate funding source.

Mr. Porter: Is such a contract authorized under VFC statutory language?

Secretary Shalala: Yes. As discussed above, the Secretary is obligated to provide for delivery of all vaccines purchased for administration to Federally vaccine-eligible children. The statute does not specify the method of delivery.

Mr. Porter: The GAO investigation of the VFC program completed last year stated that implementation of the program was incomplete in six of seven critical areas they reviews. The seven critical tasks for implementation are:

1. Vaccine contract negotiations
2. Provider enrollment
3. Provider reimbursement
4. Order processing
5. Vaccine Distribution
6. Accountability mechanisms
7. Evaluation plans

Of those, only purchase contracts negotiations were being satisfactorily implemented. Can you please give us an update on the implementation. Specifically, what progress has been made on the six areas GAO was unable to evaluate last year?

Secretary Shalala: The General Accountin Office (GAO) review of the VFC program included several fundamental flaws, including factual errors. For example, GAO staff made little effort to seek or to report the views of private physicians and associated organizations. Since VFC operates through public clinics and private providers, this was a serious deficiency in the report. In addition, GAO concluded its data gathering five months after the program started, and could not acknowledge significant program accomplishments. New programs, especially those of such complexity as VFC, require time and experience to put processes in place. The American Academy of Pediatrics and the Association of State and Territorial Health Officials have strongly supported the VFC Program.

Major progress has been accomplished in implementing the VFC program. In less than 1-1/2 years, a number of milestones have been achieved. Some include:

- ▶ **Coverage** - VFC guarantees coverage for all ACIP recommended childhood vaccines, including Hepatitis B for adolescents and catch-up MMR2.
- ▶ **Improvement in VFC Provider Enrollment** - Between October 1994 and November 1995, the number of provider sites (sites typically include a number of physicians) enrolled increased by about 80 percent, from about 20,000 to 36,000 sites.
- ▶ **VFC Vaccine Delivery** - As of March 1996, all States were delivering vaccine to the public sector, and 46 States, including Alaska, were delivering to the private sector.
- ▶ **Savings for State Medicaid and public health programs** - State public health programs are assured of purchasing vaccines at the CDC contract price, and State Medicaid programs have realized substantial savings. For example, California is reinvesting savings of about \$20 million a year to improve childhood immunization rates.
- ▶ **Vaccine Purchase Contracts** - For each of the past two years, about 18 vaccine contracts have been negotiated and signed with manufacturers to provide VFC vaccine at reduced contract prices for all vaccines routinely recommended for children.
- ▶ **VFC Accountability** - Recent CDC national and State analyses indicate VFC vaccine use is appropriate. Nationally, VFC spending is consistent with State estimates of the children who were to be served by VFC.
- ▶ **Private/Public Sector Cooperation** - Some studies report that the VFC program is reducing the referral of children away from their medical homes. For instance, New York reports a 51% decline in referrals to public health clinics. Also, significant progress has been made in building partnerships between the public and private sectors.

An update on progress for the areas addressed by GAO follows:

PROVIDER ENROLLMENT

States have made significant progress enrolling providers into the VFC program. The 80% increase in enrollment in the program's first year reflects the public and private sector's support of the program. As of November 1995, approximately 36,000 public and private provider sites were enrolled. Over 26,000 of these sites are in the private sector, with many of these involving multiple physicians.

CDC has allowed States the flexibility to establish and target their own enrollment efforts. CDC has not mandated a "one size fits all" approach to program enrollment. The creativity employed by States has resulted in the 80% increase in enrollment. Also, States are effectively targeting enrollment. An evaluation of New York State's VFC program demonstrated that, soon after the program began, 86% of the Medicaid providers who had submitted a minimum of 1,000 claims for vaccines in 1993 were enrolled in VFC.

PROVIDER REIMBURSEMENT

On October 4, 1994, HCFA published a notice in the Federal Register specifying interim maximum administration fees for providers in each State. These fees were based on charge data because of the unavailability of cost data, and the necessity to establish maximum fees before program implementation on October 1, 1994. These fee caps are also maximums and do not necessarily reflect the charges that will actually be passed on to patients.

HCFA is funding a study to develop cost, rather than charge, data on which to base State maximum vaccine administration fees. The study is expected to be completed in the summer of 1996.

In addition, the administration fee for many parents may be waived or reduced since, under the VFC program, physicians who receive publicly purchased vaccine cannot deny immunizations because of a parent's inability to pay a vaccine administration fee. However, referral to public health departments, or other public clinics, may still be made for other reasons.

ORDER PROCESSING

The VFC ordering system has operated effectively for almost two years. CDC made the correct priority decision in order to have an effective ordering system functioning to meet the legislative mandate to begin VFC operations by October 1, 1994. All 50 States and the District of Columbia continue to effectively use the system and have placed about 5,500 bulk vaccine orders and ordered over 61 million doses of vaccine. Had CDC employed the "gold standard" formal analysis procedures suggested by the GAO, ordering would have been delayed well beyond the legislatively mandated start date.

The vaccine ordering system was efficiently built on an existing vaccine ordering system. In September 1994, Logistics Management Institute (LMI), an independent group of experts in logistics and data systems, reviewed the VFC system and concluded it is effective and meets the program's needs.

CDC analyzed software and other requirements but did not have time to formalize analyses of systems requirements, alternative systems, cost benefit analysis, risk analysis, or security and disaster recovery until January 1995. LMI concluded CDC had "taken steps to assure that data and systems files are systematically backed-up. Recovery, should failure occur, would in our opinion be relatively quick and inexpensive." LMI found "hardware and software reliability to be the equivalent of similar commercial applications and sufficient to implement the VFC program."

DISTRIBUTION

VFC vaccine is being delivered to virtually every provider who would like to receive it. All States deliver VFC vaccine to enrolled public providers (about one half the vaccine in the country). Forty-six States have reported they are delivering vaccine to all VFC-enrolled private providers. Thirty-two States are delivering vaccine to private providers using health department staff/facilities, six are doing so through a contract with a commercial distributor, and eight are using a combination of health department staff/facilities and a contract with a commercial distributor. Of the remaining four States not yet distributing to private providers, two States have signed contracts with commercial distribution companies.

In addition, CDC is finalizing an RFP for a private sector vaccine distribution contract that was shared with all of the States in April 1996. States will have the option to participate in this contract. Vaccine distribution is expected to begin in the spring of 1997. All businesses involved in vaccine distribution can bid for this proposed contract(s).

ACCOUNTABILITY

Accountability is an essential component of the VFC program. States are primarily responsible for vaccine management. States have extensive experience with vaccine ordering, storage, inventory, shipping and handling and are more aware of local circumstances and provider practices than would be the federal government. Each State has submitted its accountability plan to CDC, and the approaches are varied. For example, 38 States and the District of Columbia will require vaccine usage reports as part of their accountability plan.

CDC was reluctant to impose "one size fits all" accountability restrictions upon States, as GAO suggested. It is crucial to maintain the right balance between effective accountability and accomplishing program goals. The GAO approach would have required private physicians and other providers to fill out and send in over 14 million pieces of paper a year. In fact, an HHS Inspector General report and private provider organizations warned us that excessive paperwork would prevent physicians from enrolling in the program.

CDC also evaluates the ordering patterns of the individual States. Recent national and State analyses indicate VFC vaccine use is appropriate. Nationally, actual VFC spending is consistent with State estimates of the proportion of public sector children who were to be served by VFC.

EVALUATION

It is difficult to evaluate the VFC program independently. Since VFC is one of five components of the Childhood Immunization Initiative (CII), there are complications in isolating the affect of VFC from the range of other CII efforts, such as education or infrastructure improvements, that also effect immunization coverage. Nevertheless, CDC is working with evaluation experts to develop a comprehensive VFC evaluation plan. CDC believes baseline information can be obtained from retrospective studies, thereby allowing for some comparison of pre-VFC coverage levels with coverage after VFC. Also, States are required through grant guidelines to evaluate their VFC activities.

Mr Porter: Has there been any progress and are you able to report today how many children who would otherwise not be immunized, have been?

Secretary Shalala: Significant progress has been made in the implementation of the VFC program. States are reporting many examples of achievements including provider enrollment, taxpayer savings, vaccine delivery, guaranteed and quicker access to vaccines, public/private sector cooperation, and many others. For example, New York State reports that referrals to public clinics for immunizations have declined by 51%. Michigan reports that the number of Medicaid immunizations administered between 1994 and 1995 increased by 63,000

doses. Texas reports a \$4 million Medicaid savings since the inception of the VFC program, and Kansas reports a vaccine cost savings of \$300,000. Other examples of progress and benefits of the VFC program are being reported from many States. The success of the VFC program is further reflected by the fact it is strongly endorsed by the American Academy of Pediatrics, the Association of State and Territorial Health Officials, and others.

Similar to the difficulty in measuring cost-avoidance, it would be nearly impossible to predict with absolute certainty which specific children would not have been immunized before VFC. Also, since VFC is one of five components of the Childhood Immunization Initiative, it is difficult to evaluate the VFC program independently because there are complications in isolating other CII efforts, such as education or infrastructure improvements. To assure we meet the goal of fully immunizing 90 percent of our nation's children by the year 2000, we must continue to build a comprehensive and sustainable system to assure this protection into the next century.

Mr. Porter: Could you also tell us where those children are located--in what States?

Secretary Shalala: CDC has never attempted to track the immunization status of every child. Since VFC is one of five components of the Childhood Immunization Initiative, it is difficult to evaluate the VFC program independently because there are complications in isolating other immunization variables, such as education or infrastructure improvements. However, for the first time, we now have data collected by the National Immunization Survey (NIS) which compare immunization rates in all States and 28 large urban areas. These data should help us target resources to those States and covered localities where they are most needed and will do the most good.

Mr. Porter: As the VFC Program is currently structured, vaccine manufacturers must sell their products to the States at a Federally-dictated price. In some States, that product is then sold to insurers, presumably their Health Maintenance Organizations (HMOs) - and they distribute it to all the physicians practicing within their group. The physicians then use the vaccine for all their patients, not just for VFC eligible children. As a result, the HMO profits disproportionately by receiving the vaccine supply at a controlled price and being able to charge an administration fee to their patients. Don't you find it unusual and contradictory that the Federal government should impose cost controls on one supplier in the chain while overlooking fraud and abuse in the distribution of the product? In this case price-controlled vaccine intended for a limited population? Please comment.

Secretary Shalala: CDC has not received reports and is not aware of States selling vaccine to insurers. In addition, CDC has no evidence that VFC vaccine is administered to non-VFC eligible children. Providers are supplied with the amount of VFC vaccine needed to vaccinate their VFC population. States are aware that administration of vaccine to anyone other than VFC eligibles, or the resale of VFC purchased vaccine, would be a violation of the law. CDC and the States will vigorously investigate any charges of fraud and abuse that are reported.

Some States are providing vaccines using State resources to HMOs and others for non-VFC eligible children, as allowed by OBRA 93. These States are referred to as universal purchase States. However, CDC has no evidence that universal purchase States, or any other States, are selling vaccine to HMOs.

States are primarily responsible for vaccine management. States have extensive experience with vaccine ordering, storage, inventory, shipping and handling and are more aware of local circumstances and provider practices than would be the federal government. Each State has submitted its accountability plan to CDC, and the approaches are varied. For example, 38 States and the District of Columbia will require vaccine usage reports as part of their accountability plan.

CHRONIC FATIGUE SYNDROME (CFS)

Mr. Porter: Please review the Administration's FY97 budget request for CFIDS (CFS)-related research.

Secretary Shalala: Within the Department, the primary focus for CFS research is at the National Institutes of Health and the Centers for Disease Control and Prevention. The NIH budget estimate for FY 1997 for CFS research is \$7.8 million and CDC's budget is \$5.7 million.

Mr. Porter: Please highlight recent endeavors of the HHS Chronic Fatigue Syndrome Interagency Coordinating Committee (CFSICC).

Secretary Shalala: The Department established the CFSICC on November 14, 1990. Dr. Philip R. Lee, Assistant Secretary for Health, DHHS chairs the CFSICC and the co-chair is Dr. John R. La Montagne of the National Institute of Allergy and Infectious Diseases (NIAID), National Institutes of Health (NIH). The committee is composed of representatives from the Social Security Administration (SSA), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the NIH, and CFS constituency consultants.

On April 12, 1995, the Committee held an open meeting at the Hubert H. Humphrey Building, Washington, D.C. Each participating agency provided an update of the ongoing CFS activities. The consultants raised many issues including: chartering of the CFSICC, further study of SSA disability data, need for accurate educational materials about CFS for patients and physicians. The CFSICC also heard scientific presentations on fatigue as a symptom and how it impairs functional activity and a brief summary of the recently published studies that have been investigating CFS and neurally mediated hypotension. The Committee devoted an hour of the meeting to accepting comments relating to CFS from members of the public attending.

On November 21, 1995, the Committee met by teleconference. The agency updates included a summary of the NIAID National Advisory Council's September 12, 1995 discussions of the CFS program, an update of prevalence rates of CFS in the CDC San Francisco study, and the development of an SSA fact sheet on CFS. As part of the November 21 teleconference, the Committee and the consultants were joined by guests, from the American Medical Association, the Agency for Health Care Policy and Research, the Health Resources Services Administration, and the CDC. They provided brief reports on the agency's or organization's overall efforts to disseminate CFS educational and informational items to health care practitioners.

On April 11, 1996, the Committee held an open meeting on the NIH Campus. Each agency representative provided an update on current CFS activities. Scientific presentations included work relating to NIH-sponsored therapeutic trials and adolescent CFS.

The Committee devoted an additional two hours of the meeting to accepting comments relating to CFS from members of the public attending.

Mr. Porter: Does the CFSICC efficiently maximize CFIDS (CFS) activities across the Public Health Service?

Secretary Shalala: The primary function of the CFSICC is to assure interagency coordination and communication regarding CFS research and other related issues, to facilitate increased Department and agency awareness of CFS research and educational needs; to develop complementary research programs, which reduce overlap; to identify opportunities for collaborative and/or coordinated efforts in research and education; and to develop informed responses to constituency groups regarding DHHS efforts and progress.

The CFSICC has been highly successful in increasing interagency communication and coordination of CFS research activities. This interaction has resulted in the identification of CFS research needs and modification of agency research efforts to complement ongoing research in other agencies.

Mr. Porter: What efforts have been made to ensure the ongoing success of this Committee? Specifically, when will the Committee's charter be complete?

Secretary Shalala: We have developed a draft charter and we have circulated it to members and consultants of the CFSICC for their comments. We are planning a conference to obtain final comments on the document. Following comments from the CFSICC, we will send the charter through appropriate Department and Executive Branch channels.

Mr. Porter: Will a representative from the Health Resources and Services Administration (HRSA) be added?

Secretary Shalala: The draft charter for the CFSICC includes a representative from HRSA in its membership.

Mr. Porter: Please provide a summary of the CFSICC's efforts to educate physicians about CFIDS (CFS).

Secretary Shalala: The CFSICC organized a meeting in November 1995 to discuss efforts to educate physicians about CFS. Health consultants and representatives from the American Medical Association, the Agency for Health Care Policy and Research, the Health Resources Services Administration and the Centers for Disease Control and Prevention joined the committee in these discussions. Participants at the meeting agreed that there are a variety of ways to

educate physicians about Chronic Fatigue Syndrome. These methods include established paper-based information exchange mechanisms, such as journals, patient brochures and formal interaction mechanisms such as scientific conferences and workshops, and the CFSICC itself, and informal communications between government agencies, the medical community and representatives of patient communities.

The committee is developing an Information Dissemination Document to facilitate the distribution of CFS information to the appropriate communities. This document will include a listing of Internet/WWW addresses to government agencies conducting CFS activities. This will provide an additional mechanism to link relevant Federal Government home pages already in existence and those planned for future development. This will enhance the power of the mechanisms already in place and provide an additional source of information to the medical research and patient communities and thus, enhance CFS research progress and medical care.

NIH OUTYEAR PROJECTIONS

Mr. Porter: What outyear projections are included in your budget for NIH?

Secretary Shalala: The outyear projections for NIH included in the President's budget would straightline NIH from FY 1998 to FY 2000 at the FY 1997 level of \$12.4 billion, with a 2.8% increase planned for FY 2001, and another 2.8% increase planned for FY 2002. The numbers are as follows:

NIH Outyear Projections

(Dollars in millions)

	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>
NIH..	\$12,406	\$12,406	\$12,406	\$12,406	\$12,753	\$13,110

HEAD START

Mr. Porter: The President is requesting nearly \$4 billion for the Head Start program for FY 1997. This would be an increase of \$410 million, or 11.5 percent, over the tentative conference agreement for FY 1996. That's certainly a healthy increase in this time of declining resources. In your opinion, what are the objectives of the Head Start program?

Secretary Shalala: Head Start has a number of important objectives, including:

- Preparing children for the challenges of school and everyday life, helping them perform at their highest potential;
- Improving the health of children, both in the short term while they are in Head Start and, over the longer term, by helping parents understand the importance of well balanced, nutritious meals and the importance of regular medical and dental visits.
- Helping parents deal with the problems of poverty and supporting their efforts to move toward economic self-sufficiency; and
- Helping parents become more effective in their role as the primary educators of their children;

Mr. Porter: How do you measure performance in Head Start programs? What measurements are actually used to determine if the program is doing what it is supposed to do? Do you simply say that a certain number of kids are enrolled, therefore it is successful?

Secretary Shalala: Currently, we have several ways to look at the outcomes of the program nationally and at the individual performance of each Head Start program. Annually, the Head Start Bureau collects and analyzes data from the Program Information Report (PIR) which all Head Start programs are required to submit. This information shows the percentages of children and families who receive a comprehensive array of services. The PIR also tells us about the status of teacher qualifications throughout all Head Start programs. Head Start also monitors each program on-site at least once every three years. Through monitoring, we identify both the community-based program's strengths and weaknesses and its compliance with performance standards which define high quality services. When problems are identified, the program is required to correct all areas of concern within a limited time period, never to exceed one year, or face termination proceedings.

On a more global level, we are developing measures which will assess the quality and effectiveness of the Head Start program nationally through stated outcomes for children and families and through indicators of program quality.

These tools provide us with considerable information with which to make judgments about Head Start's effectiveness, both for individual Head Start programs as well as for the Head Start program as a whole.

Mr. Porter: Can you point out to the Committee any recent evaluations of the program that would support the Administration's request for an 11 percent increase in funding?

Secretary Shalala: The research is unequivocal that Head Start, for 30 years, has worked for low-income children and their families. It helps low-income children get ready and stay ready for school. It helps parents improve their parenting skills, improve their ability and willingness to contribute to their communities and, in many cases, move toward economic and social self-sufficiency.

- Head Start helps low-income children arrive at school more ready to learn. It improves intelligence (IQ), academic readiness and achievement, self-esteem, social behavior, and physical health (including better dental and nutritional status, greater immunization rates, and periodic medical screening and treatment). (Zigler and Styfco 1993; McCall, 1993; Datta, 1979; Fosburg et al, 1984; Haskins, 1989; Mann, et al, 1976; McKey, et al, 1985).
- According to the bipartisan Advisory Committee on Head Start Quality and Expansion, "Research indicates Head Start's effectiveness. A series of substantial and careful reviews has reported that Head Start produces benefits for the children and families experiencing the program." (p.8)

In addition to the unequivocal evidence that Head Start brings children to the schoolhouse door more ready to learn, there is also substantial evidence that Head Start and other early intervention programs can have longer-term benefits for children and their families -- despite all the other things that can go wrong for low-income children.

- A new and thorough review of the literature by nationwide experts brought together by the Packard Foundation's Center for the Future of Children culled the results of nearly 150 studies to conclude that children exposed to early childhood education have higher reading scores, are less likely to be held back a grade or be put into expensive special-education classes and are more likely to graduate from high school. These effects were found for Head Start children and for children in other high quality, comprehensive early intervention programs. (Barnett, 1996).
- In addition, the Packard review found that participants in preschool programs are less likely to go on welfare or become involved with the criminal justice system. (1996)
- According to the nationwide group of experts assembled by the Packard

Foundation, the long-term educational and economic gains make Head Start and other preschool programs for low-income children a critical investment for the nation: "Given the research that documents benefits for children and dramatic disparity of enrollment rates in preschool programs across income levels, policy-makers at the Federal, State, and local levels should allocate sufficient funds for child-focused programs to ensure their availability to all disadvantaged children." (1996). Therefore, we must invest in a top quality Head Start experience if we are to achieve the President's goal, of "walking every child up to the starting line."

- An analysis of Head Start children through the age of 10 identified in the National Longitudinal Study of Youth (NSLY) found positive and persistent effects of participation in Head Start on the test scores of White and Hispanic children. (Currie and Thomas, 1993). A reanalysis of the data by Barnett and Camilli found that Head Start has persistent effects for all ethnic groups (African Americans, Hispanics, and non-Hispanic Whites), including long-term increases in at least one measure of reading achievement for all three ethnic groups and a reduction in grade repetition for all three ethnic groups (Barnett and Camilli, 1996).

At a time when we are talking about the critical need to support parents' ability to be good parents, as well as their independence and economic self-sufficiency, there is no program with a better record than Head Start of changing parents' lives. This makes a difference to children, because parent involvement enhances the effects of early childhood programs by increasing the likelihood of school success.

- Several studies show that Head Start helps to improve the lives of parents, including increased parental communication with their children, increased participation in their children's school activities, increased satisfaction with the quality of their own lives, enhanced confidence in their ability to cope and interact in society, improved disciplinary practices with their children, and decreased feelings of depression and anxiety. (Mann, et al, 1976; McKey, et al, 1985; Parker, et al, 1987)
- Parents consulted in focus groups and surveys report (according to the 1993 bipartisan Advisory Committee report) that, "Head Start [has had] a positive impact on their child's preparation for school, their own understanding of the importance of their involvement in the education of their child, their own parenting skills, and their own self-esteem and the self-esteem of their child."

Mr. Porter: In her 1992 book "Reviving the American Dream" Alice Rivlin, the former director of the Office of Management and Budget and a colleague of yours, said the following concerning Head Start: "The negative legacy of Head Start, however, is that States and communities have come to believe that the responsibility for pre-school education lies with Washington, not with them. Change would come more rapidly if concerned citizens, parents, and

educators worked to improve their own preschools instead of lobbying Washington to allocate more funds for Head Start." What is your reaction to Dr. Rivlin's statement?

Secretary Shalala: One of the unique characteristics of Head Start is the extent to which it is a community-based and community-oriented program. Citizens, parents and local leaders in communities across the country view the Head Start program as "their" program. There are over 2,000 Head Start programs located throughout the country, and each one does its job of providing Head Start services to children and families just a little bit differently in order to meet the unique needs of the community it serves. Community partnerships are an integral part of Head Start and programs are continually working in their community to promote the importance of pre-school education for all children, not just the relatively small number of low-income children which Head Start is able to serve. Head Start has often served as a catalyst to increase the interest of others in pre-school education and as a role model in how to provide effective, high quality pre-school services. Head Start has been a major influence in the significant expansion of pre-school services which has occurred in many States and localities during the last decade. Communities have seen that Head Start works, and this has persuaded them to invest their own resources in additional pre-school programs for the many children in their communities who will never be enrolled in a Head Start program.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

Mr. Porter: I have been a critic of the LIHEAP program for some time because I think the justification for the program -- historically high energy prices caused by a deliberate foreign policy pursued by the Carter Administration -- has ceased to exist. I wonder if you would tell us first, how do real energy prices today compare with real energy prices at the time this program was enacted and first funded. [Please provide a historical table for the record similar to the one provided for last year's hearing.]

Secretary Shalala: Below are summaries and tables showing both current and constant dollar fuel price trends from 1973 through 1995. Although relative prices have decreased in constant dollar terms, it is important to note that, based on data reported by the States, over 2/3 of LIHEAP recipient households have incomes below \$8,000 per year. In addition, the percent of income paid by low income households for home energy is five times that paid by non low income households.

In the data shown below, residential fuel prices for the three major fuel types--electricity, natural gas, and fuel oil--have been converted to dollars per million btu's (mmbtu) for the period of 1973 to FY 1995. Trends for a weighted average cost of energy (referred to as a composite average) were developed using weights calculated from the series of national residential energy surveys sponsored by the Energy Information Administration--the National Interim Energy Consumption Survey and the Residential Energy Consumption Survey.

Current Dollar Prices: Overall, composite average fuel prices increased steadily from 1973 to 1985, declined in 1986 and 1987, increased steadily through 1994, and then fell in FY 1995. With respect to the three fuel types:

- electricity prices reached their first peak in 1985, fell in 1986, and then rose again from 1987 through 1994. Prices did not change between 1994 and FY 1995. The FY 1995 price level is about 8% above the 1985 peak.
- natural gas prices reached their first peak in 1984 and 1985. Prices fell from 1986 to 1988, rose from 1988 through 1994, and then fell in FY 1995. Prices in FY 1995 were about 1% above the 1985 peak and 3% below the 1994 peak.
- fuel oil prices reached their peak in 1981 and then fell continuously until 1988 except for a slight increase in 1984. Prices rose in 1989 and 1990, and then fell from 1991 through FY 1995. Prices in FY 1995 were about 28% below the 1981 peak.

Constant Dollar Prices: When fuel prices are adjusted for inflation (using FY 1995 dollars), overall fuel prices rose steadily from 1973 to 1983 and have fallen steadily, except for a small increase in 1990. The FY 1995 composite average is less than the composite average for 1980. With respect to the three fuel types (see table 2):

- electricity prices peaked in 1985 and have fallen steadily since that time.

- natural gas prices peaked in 1983 and fell steadily until 1992. After increases in 1993 and 1994, prices fell again in FY 1995.
- fuel oil prices peaked in 1981, fell steadily until 1988, rose in 1989 and 1990, and then fell again from 1991 through FY 1995.

Table 1. Average price by fuel type and by year, current dollars per millions of British Thermal Units¹

Fuel Type	Calendar Year										
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Electricity	7.33	9.09	10.26	10.84	12.02	12.60	13.48	15.83	18.17	20.22	21.10
Natural Gas	1.29	1.43	1.71	1.98	2.35	2.56	2.98	3.68	4.29	5.17	6.06
Fuel Oil	1.64	2.18	2.72	2.93	3.32	3.53	5.08	7.02	8.81	8.36	7.77
Composite Average	2.82	3.44	3.99	4.32	4.89	5.19	5.96	7.39	8.85	9.70	10.68

Fuel Type	Calendar Year										
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
Electricity	21.98	22.86	21.69	21.69	21.98	22.27	22.86	23.74	24.03	24.33	24.62
Natural Gas	6.12	6.12	5.83	5.54	5.47	5.64	5.77	5.82	5.87	6.16	6.41
Fuel Oil	7.87	7.59	6.03	5.79	5.11	6.49	7.65	7.34	6.73	6.61	6.37
Composite Average	10.93	11.08	10.60	10.62	10.90	11.17	11.78	12.09	12.14	12.40	12.62

Fuel Type	Calendar Year										
	FY95										
Electricity	24.62										
Natural Gas	6.21										
Fuel Oil	6.24										
Composite Average	12.49										

¹Composite (all fuels) average is weighted, based on the amount of each fuel (i.e., electricity, natural gas, and fuel oil) purchased for residential use. Fuel prices were taken from tables 9.8, 9.9, and 9.11 of the Monthly Energy Review (December 1995, DOE/EIA-0035 (95/12)). Fuel costs were converted to dollars per mmbtu using conversion factors shown in tables A.2, A.5, and A.9 of the same issue of the Monthly Energy Review.

Average Fuel Prices In Current Dollars

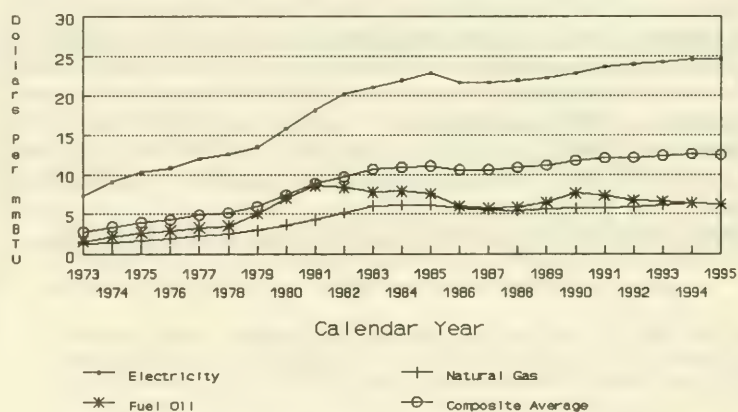


Table 2. Average price by fuel type and by year, constant FY 1995 dollars per millions of British Thermal Units²

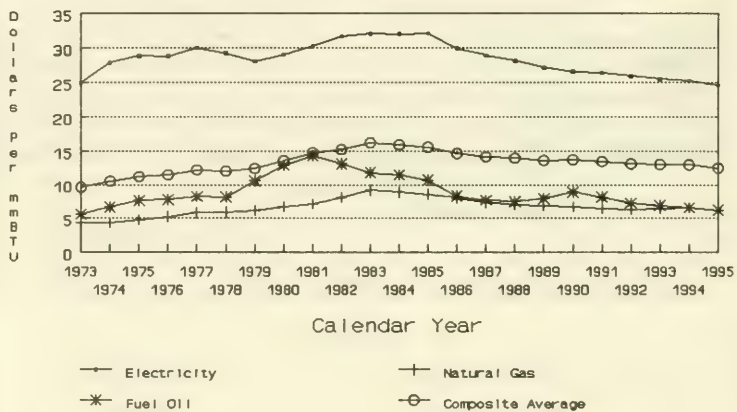
Fuel Type	Calendar Year										
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Electricity	24.98	27.90	28.87	28.85	30.02	29.26	28.11	29.08	30.27	31.73	32.08
Natural Gas	4.40	4.39	4.81	5.27	5.87	5.94	6.21	6.76	7.15	8.11	9.21
Fuel Oil	5.61	6.70	7.65	7.79	8.29	8.20	10.59	12.90	14.34	13.12	11.82
Composite Average	9.62	10.55	11.22	11.49	12.21	12.05	12.43	13.59	14.75	15.22	16.23

Fuel Type	Calendar Year										
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
Electricity	32.03	32.17	29.96	28.90	28.18	27.20	26.62	26.43	25.95	25.51	25.32
Natural Gas	8.92	8.61	8.05	7.38	7.01	6.89	6.72	6.48	6.34	6.46	6.59
Fuel Oil	11.46	10.68	8.33	7.72	7.51	7.92	8.91	8.17	7.27	6.93	6.56
Composite Average	15.93	15.59	14.64	14.16	13.97	13.64	13.71	13.45	13.11	13.01	12.98

Fuel Type	Calendar Year										
	FY95										
Electricity	24.62										
Natural Gas	6.21										
Fuel Oil	6.24										
Composite Average	12.49										

²Composite (all fuels) average is weighted, based on the amount of each fuel (i.e., electricity, natural gas, and fuel oil) purchased for residential use. Fuel prices were taken from tables 9.8, 9.9, and 9.11 of the Monthly Energy Review (December 1995, DOE/EIA-0035 (95/12)). Fuel costs were converted to dollars per mmbtu using conversion factors shown in tables A.2, A.5, and A.9 of the same issue of the Monthly Energy Review.

Average Fuel Prices In Constant Dollars



Mr. Porter: While I oppose LIHEAP, I am not necessarily opposed to an energy assistance program that would focus on emergencies (rather than on general assistance as LIHEAP does), and which would focus on the issue of dependence. Have you considered proposing a program that could be administered by local agencies, whether Community Action Programs or otherwise, that could make a hands-on determination of which households have true emergencies and then work with recipients after the fact to promote independence of future energy assistance? Wouldn't such a program provide a much less costly and more effective and proactive approach to the problem than the current program?

Secretary Shalala: As LIHEAP appropriations have declined over the last several years, several States have considered running "crisis only" programs, but to date, none have done so. Many States in recent years have had great success in helping people to plan ahead and to avoid energy crises, such as shut-off notices, by arranging budget payment plans and arrearage forgiveness programs. They have done this in conjunction with the basic LIHEAP program, which in many cases provides the small amount of assistance a household needs to avoid a crisis situation. Running a crisis only program may mean that a household will receive assistance only if it receives a shutoff notice. Thus, households may have a disincentive to pay their bills in order to qualify for crisis assistance, which may undercut the programs that have tried to reduce the number of these crises.

One of the 1994 amendments to the LIHEAP statute established a new Residential Energy Assistance Challenge Program (REACH) that will be funded for the first time in FY 1996. REACH will implement the type of program you are suggesting, but on a very small demonstration level, since funding is limited to \$5.5 million. We will closely track the results of the REACH program over the next few years.

SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION

Mr. Porter: Madam Secretary, last year this subcommittee asked the Substance Abuse and Mental Health Services Administration to consider making some fundamental changes in the way it administers its programs. We have been very pleased with the response of the Agency. In particular, we were interested in seeing a sharper focus on the purposes of demonstration grants, a focus on outcomes, how services are actually helping people, and more administrative integration. I wonder if you would generally describe the transition at the agency, and tell us specifically how, you are working with States to focus on performance and outcomes related to Federal block grant funding.

Secretary Shalala: In last year's budget proposal, SAMHSA outlined a new direction for its future demonstration programs based more on intensive knowledge development and technology dissemination. We are calling these new demonstration programs Knowledge Development and Application (KDA's). The SAMHSA Knowledge Development and Application program is designed to improve the lives of people with or at risk for substance abuse and mental disorders through effective service delivery systems.

The new approach to Knowledge Development and Application also includes high yield initiatives that are calculated both to achieve short-term positive change and to set the stage for continuous change over the long term. One area where we are witnessing dramatic change is in the managed care field. As States, counties and communities turn to managed care, they have found that the knowledge base for estimating capitation rates and risk adjustment is inadequate, especially for disabled and other vulnerable populations. SAMHSA is working closely with States, counties and community-based organizations to prepare for this rapidly occurring change.

For 1996, the President's Budget again proposes to establish new Performance Partnership programs to replace both the Substance Abuse Prevention and Treatment and Mental Health Block Grants. SAMHSA is working with the States to develop performance measures under the current statute and with accordance with the Government Performance and Results Act (GPRA) requirement. The Performance Partnerships eliminate many of the specific set-asides and earmarks of the current Block Grants, and replace them with outcome-oriented State performance measures intended to improve the State's health status. Work is underway in fiscal year 1996 to begin the intensive discussions and collaboration necessary on the performance measures in preparation for implementation of Performance Partnerships.

Finally, SAMHSA is now implementing a comprehensive set of organizational changes that are consistent with the Administration's goal to make government work better and cost less. These changes will reduce duplication, reduce overhead, strengthen programs, and more effectively deploy SAMHSA's resources. The restructured SAMHSA will help to effectively impact the Nation's service systems in an efficient manner.

RYAN WHITE AIDS PROGRAMS

Mr. Porter: Your 1997 request for Ryan White AIDS programs is \$807 million, \$100 million or 14% higher than the likely 1996 appropriation. That would mean we would be spending more on Ryan White than the entire community health centers program. As AIDS patients are living longer and science finds better treatments, the cost of the program is likely to escalate further. What are your outyear projections for the cost of the Ryan White program?

Secretary Shalala: The numbers for Ryan White AIDS that underlie the outyear estimates in the President's FY 1997 Budget are: \$831 million for FY 1998, \$854 million for FY 1999, \$878 million for FY 2000, \$903 million for FY 2001, and \$928 million for FY 2002.

However, I can assure you that each year, we will evaluate whether any changes in the epidemic should alter these projections.

Mr. Porter: Will it continue to be viable as currently structured or is the Department considering other options for dealing with the health care needs of this population?

Secretary Shalala: We fully support the Ryan White Reauthorization bill which addresses and makes modifications in the current structure of financial support for individuals with HIV/AIDS. We believe that the proposed changes to the Ryan White Act, including eligibility and funding distribution formulas, will continue to make the Ryan White programs an effective method of assisting the States and cities in addressing this epidemic.

TEEN PREGNANCY PREVENTION PROGRAM

Mr. Porter: Your budget proposes a new \$30 million teen pregnancy prevention initiative. As we understand it, you plan to make 25 grant awards at \$1 million each and spend the remaining \$5 million for training and technical assistance, etc. How will this effort differ from the numerous demonstration projects and research already supported by such HHS programs as Healthy Start, adolescent family life, and maternal and child health?

Secretary Shalala: This new initiative is unique in that it is designed to build upon existing community coalitions, support the implementation of promising prevention strategies based on current research, and include a rigorous evaluation component. The program will encourage a multi-faceted approach, combining activities which provide opportunities for youth with those that promote responsible behavior. These funds will assist urban, suburban, and rural communities that have high teen pregnancy rates, as well as a developed response infrastructure, in taking their teen pregnancy prevention interventions to the next level of effectiveness. Successful applicants for this initiative must demonstrate a commitment to building upon recently completed and reviewed research about effective approaches. Furthermore, \$5 million of the \$30 million will be designated for a multi-site evaluation, as well as training and technical assistance. In addition, grantees will use a portion of their funds for a process evaluation. Through this new project we anticipate significantly expanding our knowledge about what works and what does not work in the area of teenage pregnancy prevention.

Mr. Porter: How will this new program deal with the sensitive issue of encouraging abstinence?

Secretary Shalala: One goal of the initiative is to allow communities the flexibility they need to adopt and test promising approaches that meet their specific needs. Abstinence-based activities are a priority activity area, and in keeping with local priorities and circumstances, should be incorporated by grantees.

Mr. Porter: Do you see this as a time-limited effort of a few years' duration, or would it continue indefinitely under your planning?

Secretary Shalala: While grantees may use their funds over a multi-year period, this initiative is not intended to continue indefinitely. Because a principal goal of the initiative is evaluation and learning, a specific end point -- after which we can assess what we have learned and determine next steps -- is important.

IMMUNIZATION

Mr. Porter: Immunization rates reached record or near record levels prior to the implementation of the VFC Program. Yet, your 1997 budget proposes \$523 million in entitlement spending for vaccine purchases through the program -- in addition to \$139 million in the CDC immunization program. Would it make more sense to target expenditures to those geographic pockets with low immunization rates rather than have a broad-based vaccine purchase program for populations that already have high immunization rates?

Secretary Shalala: We believe, and the Congress has agreed, that the proper goal of national immunization efforts must be to raise immunization levels throughout the Nation, and more importantly, to put in place a sustainable system that will ensure that immunization rates remain high--through continuous access to vaccine for all eligible children. Moreover, the experience of private physicians and State Health Departments are essential to any such consideration. These groups strongly support VFC and recognize the need to build a sustainable, nation-wide system to ensure that immunization rates are even further increased.

We should not assume that general immunization rates are not now a problem and will not be a problem in the future. Our failure to sustain general immunization rates could lead to another preventable disease outbreak like the measles outbreak that occurred in 1989-1991. This resulted in 55,000 cases, 11,000 hospitalizations, and over 130 deaths. Further, pertussis remains endemic, and cases have been reported in every State in the country. Also, because of U.S. childhood immunization coverage policies, more underimmunized children live at or above the poverty level than below the poverty level.

As part of the comprehensive process to eliminate vaccine-preventable diseases, attention is also being focused on geographic areas with low immunization rates. CDC has initiated several intervention efforts to address this matter. Examples include (1) targeting WIC populations, (2) conducting record assessments using the CDC Clinic Assessment Software Application, (3) focusing CDC technical site visits to selected urban areas, (4) funding academic medical centers in targeted communities, and (5) working with the Bureau of Primary Health Care to implement interventions in Community and Migrant Health Centers.

We cannot lower our guard. Although great progress has been made, at least one million two-year-olds in America still need at least one or more doses of key vaccines. We still have a way to go to reach the Year 2000 objective of at least 90% of two-year-olds immunized with the full series of recommended vaccines. Every year, about 4 million babies are born in the U. S., or about 11,000 a day who must be immunized. We must continue to work to build the comprehensive system that will assure that, by the Year 2000, all our children will be protected against vaccine-preventable diseases.

Mr. Porter: Are low immunization rates in some areas due as much to missed vaccination opportunities and lack of knowledge as the cost of vaccines?

Secretary Shalala: The consensus is that the problem of underimmunization in the United States is multi-faceted, and the best strategy is a comprehensive approach which attacks the problem simultaneously from multiple perspectives. The strategy adopted by the Childhood Immunization Initiative (CII) is a five part program designed to tackle multiple causes simultaneously. CDC has never said that one part of the CII is more or less important than any other part. Each component is essential to assure that we reach 90% coverage and that we sustain these achievements for future cohorts of children.

The CDC has never graded the barriers to underimmunization into a hierarchy of importance. Cost is a barrier to immunization, as agreed to by the GAO and a range of independent researchers, and missed opportunities are also prevalent, as CDC has repeatedly stated. In fact, referral of children to public health clinics because of cost is one of the reasons for missed opportunities to vaccinate. However, solving missed opportunities would not raise immunization coverage levels to 90%. Because of differences in communities, racial/ethnic groups, physician practices, and other variables, a comprehensive approach is essential to address underimmunization in the United States.

NEW HEALTH INSURANCE PROGRAM

Mr. Porter: Your budget proposes a new four-year \$1.5 billion program within HCFA to provide health insurance for temporarily unemployed workers. Does this establish a new precedent for the Federal government to provide health insurance for the non-elderly, non-Medicaid population?

Secretary Shalala: This program will be a four-year capped entitlement to the State. States that choose to participate will receive annual Federal grants based on the proportion of unemployed persons in the State who collected unemployment income (UI) benefits relative to all persons in the Nation who collected UI benefits.

States will have flexibility in how they use funds to assure access to an insurance product (e.g. COBRA coverage, a private insurance product, public pool or Medicaid buy-in).

Coverage will not exceed six months (the average period of unemployment is sixteen weeks). Individuals must have had health insurance coverage through their last employer for at least the six previous months and must not be eligible for Medicaid or Medicare.

State and Federal administrative costs are included in the program grant amount.

In 1997, an estimated 3.8 million people will be covered by the Temporarily Unemployed Program. Over 50 percent of the participants are in families with married parents and children and almost 25 percent of people covered are children.

Current unemployment insurance benefits do little to address an increasingly significant hole in the safety net for our Nation's workers: unemployment often means the loss of health insurance coverage. Even when the unemployed have options such as COBRA coverage or access to an individual health plan, the cost can be prohibitively high. For those who are potentially higher risks, insurance may not be available at any price.

Under this new program, individuals who lose their health insurance when they lose their job will be eligible for premium subsidies and guaranteed access to health coverage for up to six months. The assistance will be based on the cost of a plan like the Blue Cross/Blue Shield standard option plan available to Federal employees.

HEALTH INSURANCE FOR THE TEMPORARILY UNEMPLOYED

Mr. Porter: How many States will participate? Is it realistic to think that you can resist pressures to expand and extend the program after the four-year demo ends?

Secretary Shalala: This new program will help States finance up to six months of coverage for unemployed workers and their families. The program would be available to those who had employer-based coverage in their prior job, who are now receiving unemployment benefits, and who have income below 240 percent of the poverty level. The program is voluntary, and States would have substantial flexibility in how to administer the program. If a State chooses not to participate, HHS will operate a program in that State.

DEVELOPMENTAL DISABILITIES

Mr. Porter: Your budget request for the Developmental Disabilities Act is \$121,850,000 an increase of about \$7 million over the FY 1996 tentative conference agreement.

What are the purposes of this funding, as you understand it? What are we trying to achieve?

Secretary Shalala: The increase in \$7 million over the FY 1996 appropriation represents a return to the FY 1995 funding level. This level of funding will allow us to promote positive changes in state service system capacity for people with developmental disabilities, and will increase research and training in service delivery. We are hopeful that the funding will catalyze additional funding from State and local sources as well.

Mr. Porter: How do we know that these programs are successful? How do you measure performance in these programs? Do we simply say that these programs are supposed to be serving the disabled, therefore they must be worthwhile?

Secretary Shalala: In order to better measure performance, the Administration for Children and Families is in the process of setting measurable targets for programs serving the developmentally disabled. Examples of measurable performance available at this time are:

- o For the first time in the history of the United States, every State reduced the number of individuals with developmental disabilities living in state institutions and commensurately increased the total number of people with developmental disabilities who live in housing in community settings. In fact, during the period from 1992 to 1994, states closed a total of 45 state institutions;
- o Increasingly, more children with developmental disabilities are living at home with their families and experiencing community living. More than 40 States now have Family Support legislation and programs to help families. Supports include respite care and personal assistance services. Administration on Developmental Disabilities (ADD) funding and assistance has encouraged over half of these States to adopt a Family Support Initiative targeting people with developmental disabilities;
- o Every State now has efforts to include children with developmental and other disabilities in regular classrooms. These children and their families are becoming advocates and participants in the process of ensuring that each child, including those with significant disabilities receives a quality,

appropriate education. ADD funded Youth Leadership activities to support young people with disabilities as they become involved in their schools and communities and engage in activities with others that do not have disabilities;

Mr. Porter: Are these programs coordinated with the various other programs serving the disabled, such as special education and vocational rehabilitation? And if so, how is it done?

Secretary Shalala: The programs funded by the Developmental Disabilities Assistance and Bill of Rights Act coordinate with other programs serving individuals with disabilities on an on-going basis. State Developmental Disabilities Councils include members from special education, vocational rehabilitation, and other State and local service providers. The Administration on Developmental Disabilities is also involved with the total disability community and the agencies that serve them including the Department of Labor, the Department of Education, and the Administration on Aging. For example:

- o ADD and the Substance Abuse and Mental Health Services Administration, Protection and Advocacy for Individuals with Mental Illness Program are in the process of developing final rules for the Protection and Advocacy System which support the Developmental Disabilities Act and the Protection and Advocacy for Individuals with Mental Illness Act of 1986, as amended;
- o ADD fosters coordinated policy among P&A's from related fields (such as Developmental Disabilities, Mental Illness, Individual Rights, Assistive Technology, and Client Assistance Programs) by holding a series of monthly meetings with representatives from these offices to issue guidelines, reports, and reviews.

Mr. Porter: To what extent are these programs providing direct services to the disabled? Aren't we really providing funds for bureaucratic activities such as planning, coordinating, outreach and technical assistance, rather than direct services?

Secretary Shalala: All of the ADD-funded programs provide direct and/or community-based services to persons with developmental disabilities. The Developmental Disabilities Councils sponsor innovative service demonstration projects. The Protection and Advocacy systems protect against abuse and neglect and ensure that people with developmental disabilities and their families receive appropriate legal representation. The University Affiliated Programs do research and training in cutting-edge disabilities service provision. The Projects of National Significance support advancements in the field of developmental disabilities by sponsoring research and demonstration projects in areas of overall national importance such as employment, personal assistance services, home ownership and criminal justice.

At one time the Councils were charged with a planning oriented mission, and were called "Planning Councils." That is no longer the case. Planning and coordination (or the strictly administrative or bureaucratic activities) of Council business is limited by law, and the Councils generally devote less than 21 percent of Council funding to those activities.

The UAPs have shifted outdated paradigms from a focus on expert decision-making to consumer participation, from services provided in specialized environments to community-based services, and from specialized services to a holistic approach of support for individuals with disabilities.

RESEARCH AND DEMONSTRATION

Mr. Porter: In taking action on the FY 1996 appropriations bill, this Committee expressed its desire to consolidate various social services and health services research, demonstration and evaluation funding sources throughout the Department in one place. There appeared to us to be a lack of planning and coordination in the Department with respect to these activities, leading to fragmentation of effort and possible duplication and overlap.

The Committee asked you to submit an annual budget and plan for these funds beginning with the FY 1997 budget. I don't believe that you have submitted that to us yet. Do you know when we can expect to get that?

Secretary Shalala: The Department submitted this report, entitled "Research, Demonstration and Evaluation Activities and Funding Levels Requested for FY 1997," to the Committee on March 25, 1996.

Mr. Porter: Your budget request again asks for these funds in various places in the Department, rather than consolidating them in one place. Do you believe that consolidation is a bad idea?

Secretary Shalala: As stated, a consolidated research, demonstration and evaluation (RD&E) budget and plan was submitted to the Committee. However, we also chose to maintain our request for these funds throughout the various Operating Division (OPDIV) budget requests. We believe such a display is appropriate, since RD&E authorizations and activities are, in most cases, integrally tied to the support of specific program activities; for example, the Head Start research activity supports research designed to improve various aspects of the Head Start program. By requesting RD&E funds with the programs they support, we are able to convey our overall strategy for addressing a particular problem.

Furthermore, RD&E activities are often authorized under umbrella accounts which include activities beyond RD&E (e.g., training). In such cases, appropriations are enacted for the entire account. It would be difficult to track the appropriation for a particular account if funding for various activities were requested in different parts of a budget request.

Mr. Porter: Does your Office have adequate control and supervision of these types of funding sources throughout the Department?

Secretary Shalala: As noted in our report "Research, Demonstration and Evaluation Authorities and Funding Levels in FY 1995," which was submitted to the Committee on November 7, 1995, the Assistant Secretary for Planning and Evaluation (ASPE) has been charged with the responsibility for planning and oversight of all RD&E activities Department-wide. In carrying out this responsibility, the ASPE will: issue annual guidance to the OPDIVs; review OPDIV plans for consistency with Department priorities and duplication of effort;

participate in the development and review of many individual projects, especially in the evaluation area; and prepare and disseminate an annual Department-wide report on evaluation results. I believe these actions constitute adequate control and supervision of the extensive RD&E activities throughout the Department.

Mr. Porter: How do you know that one part of the Department is not duplicating something that another part of the Department is already doing?

Secretary Shalala: As stated, the ASPE reviews the individual OPDIV plans to ensure that no duplication of effort is occurring. If any such duplication is apparent, the ASPE will work with the OPDIVs to ensure coordination of their activities.

ANTI-TERRORISM FUNDS

Mr. Porter: You are requesting \$5 million for anti-terrorism funding in the Office of the Secretary. Can you tell us how these funds would be used?

Secretary Shalala: The \$5 million was requested to begin to address the coordinated Federal, State and local government health, medical and health-related social service preparations necessary to be able to respond effectively to a terrorist event using biological, chemical, and other weapons of mass destruction. The Department of Health and Human Services (HHS) is responsible for the coordination of all Federal activities for health and medical support to States and local governments, and accordingly is the focal point for health and medical response actions. Specifically, the \$5 million request includes the following activities as part of a continuing and long-range plan:

- ▶ Planning and Evaluation (\$400,000)--Integrated planning and evaluation will be undertaken among Federal, State and local authorities to determine readiness for response and mending gaps in capacity. An annex to the Federal Response Plan (FRP) will be developed to ensure that each of the supporting roles and responsibilities of the Federal agencies are clearly defined and assets are shared appropriately. The strengthening of local government and State plans and capacity in relation to the FRP annex will begin to be addressed through cooperative agreements.
- ▶ Training (\$600,000)--Existing curricula will be referenced and new material developed for use locally for training health professionals, emergency responders and emergency managers in biological warfare and chemical warfare preparation and response. Wherever possible, existing course materials will be used. Initial training activities will be developed jointly by a Federal, State and local government health and medical working group.
- ▶ Medical Response Coordination (\$1,000,000)--To ensure a prompt medical response, medical, scientific, logistic and support personnel will be prepared and provided as part of a rapid deployment team to provide

technical assistance, procure required antidotes and antibiotics, and establish the medical support unit to coordinate the emergency response on site in case of an emergency.

- ▶ **Warning, Detection and Enhanced Capability to Identify Organisms and Chemical Agents (\$1,000,000)**--To minimize the morbidity and mortality from a chemical/ biologic agent, it is important to identify the chemical or infectious organism expeditiously so that appropriate medical treatment can be started. Critical resource gaps will begin to be filled in HHS to meet this emerging challenge. The Centers for Disease Control and Prevention (CDC) will work closely with the Environmental Protection Agency and the Department of Defense (DoD) to obtain technical assistance and environmental information for the assessment of the health/medical aspects of a specific agent. In addition to conventional techniques for identifying microorganisms, rapid immunologic and genetic probes will be evaluated and required research will begin, in close coordination with DoD. CDC will have the primary responsibility for biological and chemical agents that are not associated with products regulated by the Food and Drug Administration (FDA). FDA will be responsible for the isolation and identification of biological and chemical agents in products that it regulates.
- ▶ **Metropolitan Medical Strike Teams (\$1,000,000)**--Because fast response time is essential, special Metropolitan Medical Strike Teams (MMST) will be developed in high-risk communities. These teams will be composed of private sector health professionals who will be specially trained to meet the needs of patients with health problems related to weapons of mass destruction. It is anticipated that the cost for medical supplies, pharmaceuticals, and medical, communications and information equipment sufficient to support a 90-person team will be approximately \$250,000 per team. Eventually, each State and large metropolitan area should have access to the use of a team.
- ▶ **High Risk Disaster Medical Assistance Teams (\$1,000,000)**--Four new Disaster Medical Assistance Teams (DMAT) will be created in high-risk regions. These teams will be specially trained and equipped to deal with the needs of patients with health problems related to weapons of mass destruction. These teams differ from MMSTs in that MMSTs will be trained as the first responders to find victims, while DMATs will be trained to deal with the specialized injuries of those victims.

Mr. Porter: Why is HHS the right place for this kind of funding, rather than the Federal Emergency Management Agency (FEMA), for example?

Secretary Shalala: FEMA coordinates the Federal government's response to natural disasters and to terrorist events. FEMA delegates specific responsibilities to various Federal agencies through its Federal Response Plan (FRP) and its system of Emergency Support Functions (ESF). FEMA has delegated the responsibilities of ESF #8 (health, medical and health-related social

service responses) to HHS. HHS is the primary agency responsible for the health and medical emergency preparedness of the Federal government; other Federal Departments with specialized medical components simply do not have the expertise to address public health issues. Thus, HHS is FEMA's "action agent" for providing medical, mental health and human services to victims of catastrophic disasters. In addition, HHS has been tasked directly by the President to coordinate the health and medical response to man-made disasters produced by chemical or biological terrorism. Therefore, it is appropriate that HHS have the necessary resources to ensure readiness to deal with all major emergencies, natural or man-made, affecting the health and medical needs of the citizens of the U.S.

Mr. Porter: In the tentative conference agreement for FY 1996, \$7 million has been included for activities of this type. Is this just a follow-on to that funding, or is this something different?

Secretary Shalala: In the final FY 1996 appropriation \$7 million was provided in the Public Health and Social Services Emergency Fund to cover the continuation of core emergency preparedness activities for both natural and man-made disasters, and allows HHS to begin activities to deal with the health and medical consequences of domestic terrorism. The \$5 million requested in FY 1997 will continue OEP office operations and natural disaster responses, as well as to continue the long-term, multi-year effort to further prepare the national health and material infrastructure for responding to potential terrorist events, including the establishment of additional MMSTs and DMATs in high-risk areas.

OFFICE OF PUBLIC HEALTH AND SCIENCE

Mr. Porter: We are concerned that there could be some duplication and overlap between the immediate Office [of] the Assistant Secretary for Health and the Assistant Secretary for Planning and Evaluation. How can we be certain that this is not the case?

Secretary Shalala: The offices of the Assistant Secretary for Health (ASH) and the Assistant Secretary for Planning and Evaluation (ASPE) have distinct missions. During the transition to the new structure, the two Assistant Secretaries and their staffs have been attentive to ensuring that their respective activities remain distinct and complementary rather than overlapping and duplicative. On a day-to-day basis, the two offices maintain many functional ties both informally and formally.

Under the leadership of the ASH, the Office of Public Health and Science (OPHS)--formerly the Office of the Assistant Secretary for Health--is the focal point within the Department for major matters related to professional leadership in the Department on population-based health and clinical preventive services. The ASH has been given the responsibility for coordination across the Department in public health and science, senior external representation of the Secretary to the health professional community, and as directed by the Secretary managing the implementation of secretarial decisions across the Public Health Service OPDIVs. The ASH also provides supervision to the ten professional program offices that comprise OPHS.

The ASPE is the Secretary's principal advisor on Department-wide policy development, and has responsibility for planning and oversight of research, demonstration, and evaluation activities Department-wide. The ASPE integrates public health policy into broad health policy analyses that have Department-wide significance, e.g., insurance reform, private-market analysis, and health/welfare system changes. Moreover, the ASPE provides the Department's policy and analytical capability in connection with other cross-cutting policy matters related to human services, e.g, welfare, long-term care, and disability. These issues are not addressed by OPHS.

HHS STAFFING REDUCTIONS

Mr. Porter: In the past several years you have achieved reductions in HHS staffing, largely as a result of buyouts. Now your budget does not show any further FTE reductions from 1995 through 1997. What is your long-range strategy for achieving the additional staffing cuts that will be required under the President's plan for 1998 and beyond?

Secretary Shalala: The HHS Streamlining plan requires that we reduce 7,000 FTE or -12 percent between FY 1993 and FY 2000. From 1993 to 1995 HHS reduced FTE by 5,000 or -8 percent. Between 1994 and 1995 alone, HHS reduced 3,300 FTE or -5 percent. HHS accomplished 2,049 buyouts between FY 1993 and FY 1995, which represent 40 percent of our total FTE reduction. Given the severe dollar constraints in the budget, we decided that the most prudent course of action is to hold the Department to the FY 1995 staffing level for FY 1996 and 1997 and not return to the higher levels of our streamlining plan. In FY 1998, we will return to our streamlining plan levels which require additional reductions through the year 2000.

While buyouts have been a significant factor in enabling us to surpass our streamlining targets, other factors were also significant. Our operating divisions successfully and aggressively employed a variety of personnel management tools and techniques to achieve their streamlining targets. These included selective employment freezes, attrition, and targeted hiring to fill vacancies in critical areas.

HHS will meet its year 2000 streamlining level by continuing to focus on reducing FTE in targeted control positions, achieving targeted FTE reductions through reduced hiring and attrition in low-priority areas with reduced funding and targeting hiring increases in high-priority programs with increased funding. HHS will also continue to identify and implement reinvention initiatives that will ensure more efficient management of Department programs at reduced staffing levels.

Mr. Porter: What progress has HHS made in achieving implementation of Government Management Reform Act (Audited Financial Statements)?

Secretary Shalala: On October 11, 1995 we informed the Office of Management and Budget that HHS was committed to meeting the prescribed GMRA milestone dates, contingent on resolving several critical challenges in the preparation and audit processes.

Since that time we have developed a Departmental approach. Our twelve (12) Operating Divisions (OPDIV) will prepare Entity-wide financial statements; these will be summarized to produce HHS-wide financial statements displayed by functional categories, according to the President's budget presentation, as well as organizationally by HHS OPDIV.

We are preparing FY 1995 financial statements on a "test" basis in preparation for the FY 1996 financial statements required by GMRA. We expect to have these completed by the end of August.

Audits will be performed at the OPDIV level and each will have an audit opinion. The audit opinion of the HHS-wide financial statement will be based upon the individual OPDIV audit opinions and the accuracy of preparation at the HHS combining level.

Funding is still an issue. To date not all OPDIVs selected for audit have signed commitment agreements. Our plan for FY 1997 is to have eight (8) OPDIV audits and the HHS-wide audit. The Agency for Children & Families (ACF) audit has begun and the audit for the Center for Disease Control (CDC) will begin approximately May 15. The six other audits cannot begin pending release of funds. In addition to the OPDIV Entity audits, we plan to audit "provider type" services: two (2) accounting systems, two (2) central payment systems, and two (2) computer data centers. One central payment system audit is presently underway. The provider type audits will be made available to auditors of user OPDIV financial statements and auditors for cross-served user Agencies. These audits will reduce audit redundancy for OPDIVs which share services and will result in reduced audit costs.

FINANCIAL AND PROGRAMMATIC MANAGEMENT

Mr. Porter: From the various audits and reports you receive from both the Inspector General's Office and GAO, could you identify what you feel are the major material weaknesses in financial and programmatic management in the Department, and your plans to redress them.

Secretary Shalala: Since 1989, when the Office of Management and Budget (OMB) initiated its high-risk program, HHS has exerted significant effort to correct its most serious deficiencies that appeared on OMB's high-risk listing. OMB's purpose with its listing of high-risk areas was to provide focused corrective action monitoring on the most serious programmatic and financial weaknesses of Federal agencies. HHS's efforts paid off in full when last year OMB removed the last of seven HHS high-risk areas that had appeared on the OMB list during the last seven years.

The elimination of high-risk areas does not indicate that HHS is not confronted with material weaknesses. Internal management reviews and Inspector General and GAO reports have served as sources for the identification of numerous material weaknesses. In our December 1995, Federal Managers' Financial Integrity Act (FMFIA) Report to the President and Congress, we provide Corrective Action Plans for fifteen material weaknesses pending correction by HHS agencies. These weaknesses do not raise to the level of seriousness that would warrant placement on OMB's high-risk listing, but we do deem them important enough to track in the annual FMFIA report. Since the FMFIA program was implemented, HHS has included Corrective Action Plans on 344 different material weaknesses in its annual FMFIA reports.

In the 1995 FMFIA report we also noted that HHS components completed action in FY 1995 to correct eight other material weaknesses that had been identified in previous years. Since implementation of the FMFIA program, HHS agencies have corrected over 325 material weaknesses, which reflects a long-term commitment by HHS program managers not only to disclose problems, but to follow through on corrective action. The seven high risk areas tracked by OMB reflected the most serious of the HHS weaknesses. HHS is proud of the corrective action that led to OMB's removal of all HHS areas from its high-risk listing.

PROGRAM SUPPORT CENTER

Mr. Porter: Madam Secretary, I want to compliment you on the bold step of creating the Program Support Center. Reforms that improve administration often get little notice and small praise. As with any new endeavor, there are difficulties and one that has come to the Subcommittees's attention is the significant increase in charges to at least some of the operating divisions--in some cases the increases have been over 30%. Since the PSC has not increased services, can you explain these increases?

Secretary Shalala: The total costs for services provided to the Operating Divisions (OPDIVs) have not increased. However, the department's REGO II reinvention process identified additional services to be included in the Program Support Center (PSC) or the Office of the Secretary, with their associated costs charged to the OPDIVs through the Service and Supply Fund (SSF). This results in several OPDIVs now being charged for services that were previously funded through appropriations, and not charged out. Examples of this are the PSC's Parklawn Personnel activity which is the PSC's servicing personnel office, the OS Regional Emergency Preparedness Coordinators, and the OS Regional Health Administrators.

In this time of transition to fee-for-service we are committed to continually communicating and aggressively benchmarking in order to become a cost competitive, customer oriented service organization. As you know, the PSC was formally chartered to begin October 1, 1995, and the director (Lynnda Regan) just came on board March 3, 1996. Our second Board of Directors meeting is scheduled for May 22nd, which will be the PSC director's first. Lynnda has spent the past two months reviewing costs and talking with the Operating Divisions (OPDIVs) and PSC employees, in a continuous effort to make certain all parties involved understand and accept our new direction.

TITLE IV-A EMERGENCY ASSISTANCE

Mr. Riggs: How did your agency come to the conclusion that it no longer needed to fulfill contractual obligations under AFDC-EA Title IV-A that it had to States providing services within their juvenile justice system?

Secretary Shalala: We have always met the Department's partnership and matching obligations for all expenditures authorized for the Emergency Assistance (EA) program under Section 406(e) of the Social Security Act (the Act). During a study of EA, the Department's Inspector General questioned the allowability of certain types of EA costs. We carefully re-examined these policies in light of Congressional intent for the EA program. We concluded that costs for services provided to children in the juvenile justice system due to alleged, charged, or adjudicated delinquent behavior bear no valid relationship to the statutory purpose of EA -- to address the emergency needs of families.

Instead of disallowing Federal matching of all prior claims, we notified States that Federal funding would no longer be available for the costs of juvenile justice services. And, to minimize the impact on our partners, we allowed States that had approved juvenile justice plans more than three additional months to modify their procedures and implement this policy.

Mr. Riggs: How do you reconcile the fact that Federal law allows each State to define what they consider "emergency situations" as long as that definition is consistent with the intent of the law with the consequent denial of funding to those States even though they feel that their definitions are consistent with the intent of the original law?

Secretary Shalala: States do have wide flexibility in developing their EA programs. A State is permitted to define the types of emergencies, services and eligibility criteria it will cover so long as the program's scope is defined equitably and bears a valid relationship to the purpose of the program. But, under the scheme of cooperative federalism envisioned in the Social Security Act, Congress has delegated to the Secretary the authority to reconcile a statute's policy objectives, issue implementing regulations and necessary policy interpretations.

With respect to Emergency Assistance, the legislative history is particularly clear that the context of the program is the family. The juvenile justice system operates in the context of society rather than in the context of the family. A challenge to the Department's recent Action Transmittal announcing this policy interpretation was recently upheld in a court decision, "*Chief Probation Officers of California v. Shalala*".

Mr. Riggs: Even if you have come to the conclusion that use of these funds in the juvenile justice system are not appropriate, why did you implement this termination mid-fiscal year and not for FY 1997 and forward?

Secretary Shalala: When we determined that Federal financial participation is not available under the Emergency Assistance program for costs associated with providing benefits or services to children in the juvenile justice system, we recognized the difficult choice that we and the States faced. Since we should never have allowed these claims, we had to act to stop the practice as soon as possible. But, I wanted to give States a reasonable period of time to modify their procedures and implement this policy. Since State fiscal years vary, we allowed States to continue to claim Federal matching for costs through December 31, 1995, as an appropriate balance between State and Federal interests.

Mr. Riggs: Why did you implement termination even though the agency had approved these contracts and the described use of funds in each contract and had budgeted this money for FY 1996?

Secretary Shalala: In retrospect and following our re-examination of Congressional intent, it is clear that the State plans adding services and benefits to children in the juvenile justice system should never have been approved. Once we recognized our mistake, I initiated reasonable and expeditious action to appropriately correct the situation.

Mr. Riggs: Why did you implement termination even though these States had operated in good faith that the Federal Government would fulfill that obligation?

Secretary Shalala: When we determined that the State plans including services and benefits to children in the juvenile justice system did not meet Congressional intent, we had no choice under the Social Security Act but to end the practice.

Mr. Riggs: Was the elimination of this funding simply a means by which to make up for lack of funding elsewhere in your agency rather than have to come to Congress for a supplemental appropriation as is sometimes the case for your agency?

Secretary Shalala: Funding for Title IV-A Emergency Assistance is available to cover program needs due to the indefinite authority provided by Congress and does not need a supplemental appropriation. Our policy change about children in the juvenile justice system was solely the result of the re-examination of statutory intent, and not due to funding needs.

JOBS/GAIN

Mr. Riggs: In 1993, Lake County, California established a public/private partnership with a nationally known firm (Maximus) to finance and administer their local GAIN (JOBS) program. They made that decision in order to avoid spending local tax dollars that are desperately needed elsewhere in the community. As a result, costs to local taxpayers have been dramatically reduced as a result of this prudent contract, the statistics of the program prove beyond a doubt that the service levels to the public have been improved.

As part of the contract entered into, the firm proposed making an unrestricted annual cash donation to the County equal to the amount the County must provide as the local matching funds for this program. This was not a requirement of the request for proposal as has been indicated by your Department.

Twenty months into the contract, the Federal Government, specifically your agency, decided that the nature of the donation provided by the firm rendered Lake County ineligible for the Federal match totaling \$97,000. Although we attempted to work with your agency to address this issue in a equitable manner, it is my understanding that the decision to deny these funds remains firm.

As a result of an October 27, 1995 meeting with Mary Jo Bane/ACF, I was told that HHS would take steps to ensure that future federal policies would help facilitate, not discourage, public/private partnerships to manage JOBS programs movement in this direction. Could you provide me with information as to how the agency is doing?

Secretary Shalala: Due in part to the situation in Lake County, last summer the Administration for Children and Families (ACF) established a new advisory group to address the question of private funding, particularly in the JOBS and Foster Care programs. The purpose of the group was to establish a consistent policy across ACF's programs that would allow us to benefit more from private sources of social service funding without abrogating the protection from abuse that current law affords. The group is still analyzing several options and intends to get input from State and local representatives before proposing new rules.

Mr. Riggs: Because the crux of this entire issue was the technical definition of the term "donation" under existing appropriation law, would a possible solution to this problem be to change or clarify the existing definition of "donation" to clarify exactly what actions would qualify as such?

Secretary Shalala: We do not believe the problem in the case of Lake County's JOBS contract is caused by a restrictive technical definition of the term "donation" under existing appropriation law. It is true that appropriation law does not consider the exchange between the contractor and Lake County as a donation but rather as an offset or rebate; however, a change could open the door to dramatic and possibly harmful results in many other programs. Because we see

the value in private partnerships that you advocate, ACF has convened an advisory group to foster private sector partnerships, but in a way that makes sense and avoids any risk to the fiscal integrity of the JOBS programs.

Mr. Riggs: Why would your agency actively seek to discourage such innovative and effective JOBS programs that make prudent use of taxpayer dollars and improve services for their clients rather than find a way to encourage this type of creative financing in our counties?

Secretary Shalala: HHS actively encourages the use of private sector partnerships. The JOBS program in particular encourages collaboration at many levels and in all sectors of the community. The JOBS regulations provide for the use of privately-donated funds in the State's share of expenditures, but only under certain conditions. We included those qualifications to ensure the good stewardship of public funds and protect the program from fiscal abuse. I am committed to fostering partnerships within the bounds of those reasonable and important protections.

MANAGED CARE WAIVERS

Mr Stokes: As you know, much of the increase in managed care enrollment has resulted from the move to Medicaid managed care, and most of it was associated with managed care waivers. Can you give us an update of the status of the managed care waiver situation?

Secretary Shalala: There are two types of Medicaid waivers that include enrollment in Managed Care: Section 1115 Research and Demonstration Waivers, and Section 1915 (b) Program Waivers. This response (and those that follow) encompasses both types of waivers.

1115 Waivers:

HHS has approved 13 section 1115 State-wide demonstrations (including the long-standing program in Arizona). Of these, 9 are currently implemented. These projects include expanding Medicaid coverage to more people at no additional cost, exploring new delivery systems (often including managed care) to provide access to quality health care, testing new administrative systems, and developing methods for monitoring. These approved demonstrations when fully implemented will provide coverage to about 7 million persons including 2.2 million low-income persons not otherwise eligible.

1915 (b) Waivers:

As of March 30, 1996, HCFA had approved 91 1915(b) waivers for 41 States and the District of Columbia. Currently, 23 waivers, including initial proposals, modifications and renewals, are in process. These program waivers are more limited in scope than the 1115 waivers, and permit the state to restrict the providers from whom a recipient receives Medicaid services.

Mr. Stokes: Of those waiver demonstrations that are up and running, what have we learned from the Department's monitoring and evaluation of them?

Secretary Shalala: The information follows:

1115 Waivers:

Three 5-year evaluation contracts have been awarded to examine the impacts on: access to care; quality; utilization of services; and costs, from Federal, State, provider, employer, and beneficiary perspectives.

We will know more about these areas when the evaluations' first annual reports are completed. In the meantime, we are learning anecdotal information from implemented states that we are sharing through technical assistance meetings.

1915 (b) Waivers:

In order for a 1915(b) waiver to be approved, the Department carefully monitors how service delivery will be carried out under the waiver. Access to services must be at least comparable to access under a traditional fee-for-service system, internal and external quality assurance programs must be in place, cost savings for the past waiver period must be documented, and cost savings for the next waiver period must be projected.

The recent release of "Medicaid HEDIS" and the refinement of the Quality Assurance Reform Initiative (QARI) will allow state and federal partners to better measure the quality of care being delivered to Medicaid recipients. Since these tools are so new and are not requirements of the program, it will be a few years before we are able to use the collected data to evaluate the overall effectiveness of these programs.

Mr. Stokes: What percentage of Medicaid recipients are now in managed care plans?

Secretary Shalala: Approximately 32 percent of Medicaid recipients are now in managed care plans.

Mr. Stokes: Where are we with regard to ensuring that enrollment in these managed care plans translates into timely access to quality, and culturally sensitive care?

Secretary Shalala: The information follows:

1115 Waivers:

HCFA is developing models for monitoring the quality of care and services. These models include methods of measuring effects on beneficiaries and direct technical assistance to States on data-driven quality monitoring techniques and encounter data.

HCFA establishes guidelines in the Special Terms and Conditions for each approved demonstration project, including considerations such as: travel time to the primary care delivery site, and appointment/office waiting time. Further requirements for emergency and specialty care are also delineated in the Terms and Conditions.

Quality monitoring occurs through the combined efforts of Regional Offices, State Medicaid Agencies, managed care plans, and external evaluations. States require by contract that managed care plans develop Internal Quality Assurance Programs (QAPs). States monitor plans' adherence to QAPs through data analysis (i.e., looking at selected "tracer" conditions to review health status and physician performance) and on-site visits.

1915 (b) Waivers:

In order for a 1915(b) waiver to be approved, access to services must be at least comparable to access under the fee-for-service system, and internal and external quality assurance programs must be in place. States are required to answer numerous questions about quality, such as State plans to evaluate quality of service delivery, and adequacy of data gathering and monitoring. In addition, the States must answer questions about access, such as what services will be covered under the plan, and how transportation will be provided. Finally, HHS asks the States to provide information about culturally sensitive care, such as the availability of educational materials in appropriate languages and reading levels.

WELFARE REFORM WAIVERS

Mr. Stokes: When you appeared before this subcommittee last year the Congress was in the midst of welfare reform deliberations.

You may recall that I asked your professional judgement of the proposal under consideration, at that time, by the ways and means committee. You responded that the subject proposal was "not Welfare Reform but budget cutting. You also described it as being weak on work. [Note page 122]

What is your overall basic assessment of the welfare reforms that are now taking place back at the state level?

Secretary Shalala: Taken together, these reforms are the basis of ending welfare as we have known it. They generally reflect the change in AFDC from an unconditional entitlement to a program that emphasizes social contracts between recipients and State agencies. Under these arrangements, recipients will come to participate in work-directed activities designed to help their families become self-sufficient and to act responsibly as parents.

Mr. Stokes: Will you give us an assessment as to where we are: the number issued, to what extent are they real reform, not just budget cutting, which are showing real progress, and which aren't, and why?

Secretary Shalala: This Administration has approved 59 welfare reform demonstrations in 37 states. Most entail broad-based reform with the objectives of promoting responsible parenthood and moving recipients from welfare to work through such provisions as tougher work and training requirements and incentives that make work pay.

In terms of budget cutting, the experience to date in most States is that these demonstrations are not producing significant differences in Federal outlays (most are within 1 percentage point of baseline expenditures).

While overall, most demonstrations appear to be essentially cost neutral (with respect to AFDC, Food Stamps, and Medicaid), it is clear that in many States with AFDC savings, the emphasis on work and participation in JOBS has led to corresponding increases in child care costs. However, it is also important to be careful in assessing these findings, because many State demonstrations may include provisions likely to result in up-front costs, but also include provisions that are likely to produce savings as the demonstrations progress.

Currently, we are beginning to see benefits where States are making the necessary investments to fully implement their reforms, particularly in directing stronger management and staff focus toward helping families become self-sufficient.

Mr. Stokes: What provisions have been built into the waivers to ensure that they are not just budget cutting exercises, what are the substantive terms and conditions?

Secretary Shalala: We adhere to the requirement in section 1115 of the Social Security Act that such waivers, in our judgment, are likely to assist in promoting the objectives of titles XIX and part A and D of title IV applicable to the Medicaid, Aid to Families with Dependent Children and Child Support Enforcement programs. Most welfare reform proposals do not clearly cut costs, but contain a mix of individual provisions that restructure expenditures towards more primary objectives such as moving recipients from welfare to work. Anticipated gross savings from tougher work and training requirements are typically offset by higher expenditures for child care or increased income disregards and resource limits used as a further incentive to work.

WELFARE REFORM AND MINIMUM WAGE

Mr. Stokes: In your professional judgement, to what extent is meaningful welfare reform linked to increasing the minimum wage? If necessary, you may want to elaborate further on your response in the record.

Secretary Shalala: The goal of welfare reform is to put more parents to work so they and their families can become self-sufficient. True welfare reform must emphasize work, promote personal responsibility and protect children. However, to get off welfare, parents must be able to earn wages that make it possible for them to support their families. Making work pay is an integral part of welfare reform. An increase in the minimum wage would greatly enhance our welfare reform goals.

With a minimum wage of \$4.25 an hour, a full-time, year-round minimum wage worker only makes \$8,500 a year. That's not enough to support a family and not enough to move one's family out of poverty. Eighty one percent of the minimum wage increase that was passed in 1989 and went into effect in 1991 has been eaten away by inflation. If the minimum wage is not increased this year, its real value will drop to the lowest point that it has been in the last 40 years.

Two thirds of all minimum wage workers are adults, and three out of five are women. Most of them earn the bulk of their families' income. When the minimum wage is so low, employment can mean less income rather than more income than welfare. How can we argue that work is better than welfare if work does not pay?

More working families than at any time in the last 30 years are in poverty. In the mid-1970's about 7.5 percent of working families remained under the poverty line. In the mid-1980's that portion grew to about 9.5 percent. Now in the mid-1990's about 11.5 percent of all working families in the United States are poor.

Working families struggling at low wage levels are vulnerable to the smallest financial setbacks. Even when such families "play by the rules" and try their best to avoid going on welfare, they often cannot make it. A bout of illness or a sudden rent increase can force them back on the rolls. From the very beginning, this Administration has taken steps to make work pay. President Clinton is proposing to raise the minimum wage by 90 cents over two years. Together with his already enacted EITC expansion, this minimum wage increase would offer much greater opportunities and hope for families that are trying their best to move from welfare to work.

Mr. Stokes: Last year you outlined for the subcommittee what the Department considers to be the criteria against which reform should measure up to: [p. 184]

1. Moves people from welfare to work;
2. Provide adequate education, training, and child care to enable welfare recipients to become self-supporting;
3. Encourages parental responsibility;
4. Protect the health and nutrition of children; and
5. Enhance state flexibility.

To what extent are the State waiver plans being held to this criteria?

Secretary Shalala: We have continued to approve waivers providing States enhanced flexibility to implement welfare reform plans. These plans adhere to the criteria I previously outlined. Typically they are broad-based initiatives whose overall features emphasize moving people from welfare to work and promoting self-sufficiency and parental responsibility. These approvals have also continued to fully protect the Medicaid and Food Stamp benefits of families as they would exist under current law. Each Federal-State agreement on comprehensive welfare reform demonstrations requires rigorous evaluation to determine the impacts of the reforms on employment and earnings, benefit receipt, and child well-being.

BREAST AND CERVICAL CANCER SCREENING

Mr. Stokes: Last year, you told us about your Department's multifaceted effort to understand racial difference in breast and other cancers, to help reduce survival discrepancies through improved access to early detection for African Americans and other minority populations. What progress do you have to report to us on this initiative since you were last here?

Secretary Shalala: CDC's National Breast and Cervical Cancer Early Detection Program's screening guidelines place a high priority on reaching women from racial and ethnic minorities. As of September 30, 1995, approximately 800,000 screenings have been provided to eligible women through this program, which began in 1992. A review of the Program's records reveals that 50.9 percent of the mammograms and 50.5 percent of the Pap tests were received by minority women.

CDC continues to strengthen efforts to screen minority women in all State programs. State efforts include culturally-sensitive cancer education, community-based facilities to provide clinical breast exams and screening mammograms, and community outreach programs.

Additionally, CDC works with national organizations to reach specific populations. In fiscal year 1995, CDC provided more than \$2,000,000 to 12 national organizations, including the National Caucus on Black Aged, Inc., the National Coalition of Hispanic Health and Human Service Organizations, the American Indian Healthcare Association, and the YWCA of the USA to educate their constituents about breast and cervical cancer, to increase access to breast and cervical screening among target populations, and to develop strategies for reaching target populations in collaboration with State health agencies.

HEALTH PROFESSIONS

Mr. Stokes: More than a decade after the Department's task force report on Black and minority health the health disparity gap continues and in some cases has widened. As I am sure you would agree, we must concentrate our energies and resources to close the health disparity gap. It is against this backdrop that I am most concerned about the Department's proposal with respect to health professions training programs. Your proposal to cluster the minority/disadvantaged health professions training programs, and to cut them by \$17 million would dismantle many of those authorized by the Disadvantaged Minority Health Improvement Act such as the minority centers of excellence program, scholarships for disadvantaged students and the health careers opportunity program.

Specifically, what research analysis, and evaluations were performed that determined that it was in the best interest of the health minority and that of other disadvantaged population to dramatically cut funding for programs funded under the Disadvantaged and Minority Health Improvement Act. For the record, include the detailed analysis and evaluation that was performed and a copy of each document or report consulted.

Secretary Shalala: I fully agree that there remains a health disparity gap to which we all committed to closing. I would note that the overall HHS discretionary budget request for FY 1997 includes \$738.5 million in direct minority health spending, about the same overall level as in FY 1996.

While funding for the minority health professions cluster has decreased by \$16 million, it is important to note that this cluster is only one part of five comprehensive health professions clusters. This year there is a major focus on health professions training for primary care and nursing education as a means to increase access to primary care for underserved groups -- including minorities. Within an overall request of \$366.3 million for Health professions, the minority/disadvantaged cluster provides \$64.1 million.

In that regard, I would like to share with you a recent Institute of Medicine study, "Primary Care, America's Health in a New Era", which recommends that the current level of effort to increase the supply of primary care clinicians be continued that these primary care training programs and delivery systems focus their efforts on improving the competency of primary care clinicians and on increasing access for populations not now receiving adequate primary care."

TEEN PREGNANCY PREVENTION INITIATIVE

Mr. Stokes: I was pleased to see that the administration has strengthened its commitment to addressing teen pregnancy. This is a national problem that can and must be dealt with. The budget request includes \$30 million for the enhanced teen pregnancy initiative. As I am sure you will agree, community based organization involvement will be absolutely critical to the success of the initiative, would you briefly outline the role that community based organizations will play?

Secretary Shalala: Communities and community-based organizations are central to this new teen pregnancy prevention initiative. Community-based organizations and consortia will be eligible grantees for these funds. The initiative is aimed at building on the efforts of communities that have both demonstrated a commitment to broad-based problem-solving and have established an appropriate infrastructure from which to effectively launch and implement proposed strategies. The Department will seek input from community-based organizations, as well as other groups and individuals working in the field, in both developing the criteria for selection of projects as well as the selection process itself.

HEAD START

Mr. Stokes: As we examine Head Start and look to strengthen the program, where is the majority of emphasis expected to be placed and why?

Secretary Shalala: As we look to strengthen Head Start, we should be guided by the three broad principles established by the Advisory Committee on Head Start Quality and Expansion in 1993:

- We must ensure that every Head Start program can deliver on Head Start's vision, by striving for excellence in serving both children and families.
- We must expand the number of children served and the scope of the services provided in a way that is more responsive to the needs of children and families.
- We must encourage Head Start to forge partnerships with key community and State institutions and programs in early childhood, family support, health, education and mental health, and we must ensure that these partnerships are constantly renewed and recrafted to fit changes in families, communities, and State and national policies.

We must, in short, be able to assure that quality is the watchword for all Head Start programs throughout the country and that all children and families enrolled in Head Start have a right to expect a high quality, effective program. We must make careful judgments in allocating our resources, balancing the need for investing in quality while ensuring that the dollars are being used in as cost effective a manner as possible so that we can continue to increase the number of children we are able to serve. And, we must help Head Start programs to work as one of many players in their communities which, collectively, can help some of this country's most disadvantaged families improve their lives.

Mr. Stokes: What have we learned with respect to the long term benefits of Head Start?

Secretary Shalala: We have learned that Head Start is a program which works, over both the short and the longer term. The research is unequivocal that Head Start, for 30 years, has worked for low-income children and their families. It helps low-income children get ready and stay ready for, school. It helps parents improve their parenting skills, improve their ability and willingness to contribute to their communities and, in many cases, move toward economic and social self-sufficiency.

- Head Start helps low-income children arrive at school more ready to learn. It improves intelligence, academic readiness and achievement, self-esteem, social behavior, and physical health (including better dental and nutritional status, greater immunization rates, and periodic medical screening and treatment). (Zigler and Styfco 1993; McCall, 1993; Datta, 1979; Fosburg et al, 1984; Haskins, 1989; Mann, et al, 1976; McKey, et al, 1985).
- According to the bipartisan Advisory Committee on Head Start Quality and Expansion, "Research indicates Head Start's effectiveness. A series of substantial and careful reviews has reported that Head Start produces benefits for the children and families experiencing the program." (p.8)

In addition to the unequivocal evidence that Head Start brings children to the schoolhouse door more ready to learn, there is also substantial evidence that Head Start and other early intervention programs can have longer-term benefits for children and their families -- despite all the other things that can go wrong for low-income children.

- A new and thorough review of the literature by nationwide experts brought together by the Packard Foundation's Center for the Future of Children culled the results of nearly 150 studies to conclude that children exposed to early childhood education have higher reading scores, are less likely to be held back a grade or be put into expensive special-education classes and are more likely to graduate from high school. These effects were found for Head Start children and for children in other high quality, comprehensive early intervention programs. (Barnett, 1996).
- In addition, the Packard review found that participants in preschool programs are less likely to go on welfare or become involved with the criminal justice system. (1996)
- According to the nationwide group of experts assembled by the Packard Foundation, the long-term educational and economic gains make Head Start and other preschool programs for low-income children a critical investment for the nation: "Given the research that documents benefits for children and dramatic disparity of enrollment rates in preschool programs across income levels, policy-makers at the Federal, State, and local levels should allocate sufficient funds for child-focused programs to ensure their availability to all disadvantaged children." (1966) Therefore, we must invest in a top quality Head Start experience if we are to achieve the President's goal, of "walking every child up to the starting line."

- An analysis of Head Start children through the age of ten identified in the National Longitudinal Study of Youth (NSLY) found positive and persistent effects of participation in Head Start on the test scores of White and Hispanic children. (Currie and Thomas, 1993). A reanalysis of the data by Barnett and Camilli found that Head Start has persistent effects for all ethnic groups (African Americans, Hispanics, and non-Hispanic Whites), including long-term increases in at least one measure of reading achievement for all three ethnic groups and a reduction in grade repetition for all three ethnic groups (Barnett and Camilli, 1996).

At a time when we are talking about the critical need to support parents' ability to be good parents, as well as their independence and economic self-sufficiency, there is no program with a better record than Head Start of changing parents' lives. This makes a difference to children, because parent involvement enhances the effects of early childhood programs by increasing the likelihood of school success.

- Several studies show that Head Start helps to improve the lives of parents, including increased parental communication with their children, increased participation in their children's school activities, increased satisfaction with the quality of their own lives, enhanced confidence in their ability to cope and interact in society, improved disciplinary practices with their children, and decreased feelings of depression and anxiety. (Mann, et al, 1976; McKey, et al, 1985; Parker, et al, 1987)
- Parents consulted in focus groups and surveys report (according to the 1993 bipartisan Advisory Committee report) that, "Head Start [has had] a positive impact on their child's preparation for school, their own understanding of the importance of their involvement in the education of their child, their own parenting skills, and their own self-esteem and the self-esteem of their child."

Mr. Stokes: I understand that the Head Start investment pays off at up to about grades four and five, is that so? To what extent are there initiatives or discussions underway between your Department and the Department of Education to prolong the benefits of Head Start?

Secretary Shalala: There is considerable recent research which suggests that the benefits of Head Start do not dissipate in Grades four or five but, in fact, continue far beyond that period. As noted in my above response, we believe that Head Start's effects are powerful and long lasting.

Head Start helps low-income children get ready and stay ready for school by helping children arrive at school more ready to learn. It improves academic readiness and achievement, self-esteem, social behavior, and physical health (including better dental and nutritional status, greater immunization rates, and periodic medical screening and treatment). (Zigler and Styfco 1993; McCall, 1993; Datta, 1979; Fosburg et al, 1984; Haskins, 1989; Mann, et al, 1976; McKey, et al, 1985).

Despite all the other things that can go wrong for low-income children, there is evidence that some things do work to change the lives of these children. A new and thorough review of the literature by nationwide experts brought together by the Packard Foundation's Center for the Future of Children culled the results of nearly 150 studies to conclude that children exposed to early childhood education have higher reading scores, are less likely to be held back a grade or be put into expensive special-education classes and are more likely to graduate from high school. These effects were found for Head Start children and for children in other high quality, comprehensive early intervention programs. In addition, the Packard review found that participants in preschool programs are less likely to go on welfare or become involved with the criminal justice system. (Barnett, 1996)

We are committed to ensuring that all Head Start programs provide the quality services that are most likely to make a long-term difference. Our monitoring, training and technical assistance, and data collection efforts are all aimed at improving or replacing any program which is not capable of delivering high quality services.

We are also committed to working with the Department of Education and with local school systems to assure the continued benefits accruing to Head Start children. We have funded, for example, 31 demonstration projects which are designed to find better ways to facilitate the transition of children from Head Start to the public schools. When these demonstrations end in FY 1997, we will inform Head Start grantees about the results of these demonstrations and will allocate the funds previously used to support these projects to grantees to improve the transition activities which they undertake with their local school systems.

We have worked closely with the Department of Education in a number of areas. As one significant example, we spent considerable time working with the Title I program at the Department of Education in developing the revised Head Start Program Performance Standards which were recently published in the "Federal Register" for public comment. The standards relating to Education and Early Childhood Development will apply to all Title I preschool programs with the exception of Even Start beginning in FY 1997.

MEDICARE TRUST FUNDS

Mr. Stokes: I understand that the Administration is proposing to make the safeguarding of the Medicare Trust Funds a Mandatory Entitlement activity. What are the advantages and disadvantages of the funding status, and how would the American people benefit?

Secretary Shalala: In the past these activities have been funded under the discretionary spending caps which have not kept pace with workload demands or inflation. The Administration's proposal for funding Medicare anti-fraud and abuse activities creates stable, mandatory funding to fight fraud and abuse in Medicare. This proposal ensures that we will be able to both launch and sustain an attack against those who steal from and abuse the trust of the program.

Our Medicare anti-fraud and abuse activities are designed to guard against one of the major criticisms that GAO has made of similar discretionary efforts by documenting savings from our activities. In Medicare, we are carefully monitoring and tracking spending related to the increased efforts so that we can support our savings estimates. CBO has reviewed our prior efforts in this regard and has estimated base savings of at least \$7 for each dollar spent on these efforts. We have established a major evaluation component to document savings and other benefits from the ongoing demonstration, "Operation Restore Trust," which we initiated last year.

Both in the Medicare Anti-Abuse Program, administered by the OIG, and in the Medicare Beneficiary Integrity System, administered by HCFA, we will have new approaches and authorities for cracking down on fraud and abuse. This is not just a matter of doing more of the same old thing. We will combine law enforcement and policy making efforts of the OIG, HCFA, and AOA in HHS, as well as the FBI and Justice Department, State Medicaid Fraud Control Units and states' attorneys general; we will give HCFA additional contracting discretion to work with the organizations that are best equipped to implement payments safeguards.

MINORITY INVOLVEMENT

Mr. Stokes: To what extent has progress been made with respect to the involvement of minority scientists in NIH planning and decisionmaking?

Secretary Shalala: Over the past year, NIH has focused attention on improving the diversity of all occupations, with particular emphasis on scientific and senior level administrative positions. As part of this focus, a new Affirmative Action Planning Process (AAPP) was undertaken at NIH as a pilot to increase the pool of applicants recruited for employment as well as training and development programs. The pilot NIH AAPP was approved on April 25, 1995, and distributed to the Institute and Center (IC) Directors for individual plan development. Each AAPP included, for the first time, establishment of IC hiring and promotion goals, timetables, and direct accountability for accomplishment of goals. The pilot program takes into account substantial underrepresentation of EEO groups, the availability of such groups in the relevant job category or field of expertise, and the level of hiring the NIH ICs anticipate.

NIH made gains in hiring and promotions at the senior level for minorities during FY 1995. While gains for the most severely underrepresented groups (Hispanics and Native Americans) are modest, NIH is pleased that its long-term outreach efforts have begun to bear fruit. Overall, the proportion of full-time permanent GS-15s who are minorities increased from 10.6% at the end of FY 1994 to 11.3% at the end of FY 1995. The proportion of full-time permanent SES employees who are minorities increased from 6.4% at the end of FY 1994 to 8.3% at the end of FY 1995. NIH's AAPP pilot will be in effect through FY 1996 and will be evaluated at the end of September.

In addition, this year, NIH is participating in a new pay system, the HHS Senior Biomedical Research Service (SBRS). A policy board was created to evaluate NIH scientists and outside recruits for acceptance into the SBRS. The SBRS is looked upon as an excellent recruitment tool for increasing diversity. The SBRS expands salary levels and benefits as well as providing the flexibility of a portable retirement system. These incentives should make the NIH more competitive in recruiting the small pool of highly qualified scientists. The policy board that assesses candidate eligibility for SBRS is diverse in its make up.

Mr. Stokes: To what extent do NIH processes and procedures offer equitable opportunities for minority scientists to propose NIH sponsored research, to help ensure participation in intramural and extramural research?

Secretary Shalala: NIH has several initiatives underway to increase opportunities for minority scientists to participate in intramural and extramural research. For example, NIH has developed a two-prong strategy to increasing the participation of Historically Black Colleges and Universities (HBCUs) in biomedical research. This comprehensive strategy is being coordinated by NIH's Office of Research on Minority Health (ORMH), in collaboration with the Institutes.

The first prong has involved developing new pilot programs and expanding existing program activities which focus primarily on minority institutions and minority investigators. These initiatives include such programs as the Minority Access to Research Careers (MARC) Program; the Minority Biomedical Research Support (MBRS) Program; the Research Centers in Minority Institutions (RCMI) Program; the Minority High School Student Research Apprenticeship (MHSSRAP) Program; the Minority International Research Training Program; and the Bridges to the Future Program. These programs provide funding to strengthen research capabilities of minority institutions and to increase the participation in biomedical research of faculty and students from high schools, two- and four-year colleges and universities, and health professions schools. Funds for these and other NIH minority training programs have increased in the aggregate approximately 7% between FY 1995 and FY 1996, and nearly 18% since FY 1993.

The second prong of NIH's strategy addresses the need to strengthen the ability of HBCUs to participate in the NIH competitive grant awards process. This facet is significant because the majority of the research sponsored by NIH is supported through this process. The NIH strategy has included three initiatives in this regard: a) Technical Assistance Workshops for HBCUs to work with ORMH to improve their grant writing abilities and thus, increase their success in applying for NIH grants; b) Institutional Research Supplements Program to foster meaningful collaborations between minority and majority institutions by assisting majority institutions to recruit minorities into clinical trials and allowing minority institutions to better understand the resources and expertise needed to conduct biomedical research; and c) Research Supplements for Underrepresented Minorities Program which provides administrative supplements to NIH grantees to use to attract and develop minority faculty and students into the field of biomedical research.

In addition, NIH has developed a policy that requires all NIH training program directors to actively recruit minorities into their training programs. Furthermore, NIH supports several intramural programs that are targeted to individuals from disadvantaged backgrounds who agree to serve as NIH research employees in exchange for loan repayment or scholarships.

COORDINATION

Mr. Hoyer: Often, details of statute and regulations make it difficult to coordinate services to children and families. What efforts is the Department making to coordinate these services with each other?

Secretary Shalala: The Department has made a concerted effort in recent years to ensure that services to children and families are better coordinated. As you may know, the Administration for Children and Families was established to facilitate such coordinated efforts by providing a single agency to oversee a number of children and family programs.

The Department recently established the Governing Council on Children and Youth which brings together senior representatives from all parts of the Department to facilitate integrated, comprehensive strategies for serving children, youth and their families. The Council goals include:

- Exercising leadership by recommending priority areas for investments of attention and resources;
- Fostering communication and building relationships across the Department, between HHS and other Departments, States and local governments, and private sector organizations in order to maximize the impact of Federal resources;
- Improving the quality, comprehensiveness and availability of services both by removing barriers and by facilitating collaborative initiatives that streamline services delivery for children, youth and their families.

In addition, the Domestic Policy Council at the White House has begun an initiative called "Partnerships for Stronger Families." To launch this initiative, a working conference was held in March, convening representatives from 14 states, with officials from across the Federal government to share innovations, to brainstorm and to strategize about building capacity, strengthening systems, improving accountability, streamlining bureaucracy, and financing comprehensive strategies for improving the lives of children and families. In follow-up to the conference, HHS and other federal agencies are exploring ways to operationalize the ideas and recommendations that emerged from the conference.

Mr. Hoyer: I am particularly interested in efforts to rationalize, or where possible reduce and eliminate, regulations that serve as barriers to coordination. Has the Department been in contact with the authorizing committee regarding legislation that may be needed to facilitate coordination?

Secretary Shalala: Many different factors come into play when local service providers begin trying to better coordinate services. In some cases, Federal regulations or statutes pose a barrier. In other instances, State laws or regulations come into play. In still other cases, the different practices or philosophies of different professions or service providers pose a challenge to collaboration.

The Department has been working to reduce barriers on several fronts. For instance, we have been working closely with the communities that are recipients of funds under the Empowerment Zones/Enterprise Communities (EZ/EC) initiative to identify options for eliminating barriers that they have encountered in the implementation of their strategic plans.

We have proposed legislation to establish Performance Partnership Grants with the States that would eliminate many specific set-asides and earmarks of current health programs and consolidate current small categorical programs. The States will be given greater flexibility to spend funds, but will be held accountable for making progress in achieving mutually agreed-upon performance-based outcomes.

The passage of bi-partisan welfare reform legislation which gives States greater flexibility in determining program requirements and self-sufficiency measures will greatly assist State and local initiatives to improve coordination among the relevant programs.

Mr. Hoyer: What incentives has the Department created to encourage different programs to coordinate?

Secretary Shalala: The Department has been engaging in a wide variety of activities to encourage coordination among different programs, both at the Federal level and at the State and community levels where families receive services.

As mentioned above, the Department has established the Governing Council on Children and Youth, which is helping to facilitate collaborative activities and to focus attention on common strategies for better serving children and their families at the community level. One activity supported by the Council is the Healthy Child Care Campaign, co-chaired by the Child Care Bureau in ACF and the Maternal and Child Health Bureau in HRSA. This effort is designed to promote sound health and positive child development for children in child care. A Youth sub-council has also been formed to examine policy options for coordinating and improving youth development services and for coordinating youth-oriented public education and outreach activities.

The Department has also worked to improve linkages at the State and local levels. One example is the Family Preservation and Family Support Program. Through this program, strong efforts were made to involve diverse partners in a comprehensive planning process. Partners included health agencies, schools, advocacy organizations, community-based organizations, and parents. The comprehensive planning process led many States to identify goals and objectives relating to education, health, economic stability, and system reform in their five-year plans.

Mr. Hoyer: What efforts is the Department making to coordinate and co-locate services with those offered by other Departments, such as job training, housing and elementary schools?

Secretary Shalala: The Department participates in a variety of activities involving other Departments. For example, interagency technical assistance efforts among the Departments of HHS, Labor, and Education have been through the joint support of the JOBS technical assistance contract. We have worked together on a number of projects including national and regional conferences, training materials, and other publications. We have focused much of our effort on a series of regional workshops entitled "Fostering Service Integration: New Direction/New Ideas," which were designed to help State and local interagency teams plan better ways of providing integrated services to welfare recipients. Another major initiative has focused on working better with employers to increase employment opportunities for JOBS participants.

Another important interagency initiative involving these three Departments is under the auspices of the National Institute for Literacy (NIFL). A number of State grants have been awarded by NIFL to develop a coordinated performance measurement system offering basic skills and literacy-related services. All three Departments are supporting this effort and have participated in related academies designed to provide technical assistance to these grantees. We have also worked closely with the Departments on welfare and interagency-related employment and training initiatives.

With respect to housing, our Department and the Department of Housing and Urban Development (HUD) are providing training and jobs creation activities for low-income residents in HUD assisted housing. The Step-Up program is a training and employment preparation program in construction and maintenance occupations for public housing residents. HHS provides the income support, job skills training and supportive services in order to facilitate self-sufficiency of the population in HUD assisted housing. There are 17 approved Step-Up sites. We are continuing efforts to increase the number of Step-Up sites, as well as the number of JOBS participants in the Step-Up program.

HHS is also involved with the Education/Literacy Initiatives with emphasis on "Education Goals 2000." In addition to coordination with the Department of Education, we participate in discussions with State and private educational organizations such as the National Institute for Literacy, National Adult Literacy and Learning Disabilities Center, State Education Director's Association, National Literacy Coalition, and the National Center for Family Literacy.

HEAD START

Mr. Hoyer: I understand that the Department has been working on new performance standards for the Head Start program, as required by the 1994 reauthorization. At what point in development are the new performance standards? Do these performance standards focus more on outcomes, rather than process?

Secretary Shalala: The proposed Head Start Program Performance Standards were published in the Federal Register on April 22, 1996 for a 60 day public comment period.

These performance standards provide the foundation for quality outcomes for children and families by defining the comprehensive services that must be provided by Head Start programs for children ages birth to five years. They are based on research which indicates that such services have positive outcomes for children. At the same time that the proposed rule implements a range of new statutory requirements and complies with the statutory mandate to ensure that there is no reduction in services, we have sought the least burdensome approaches to regulation in order to protect grantee flexibility to innovative and achieve quality outcomes in the most effective way possible. In addition, we have asked commenters to share their ideas on ways to make the performance standards more outcome-focused.

Mr. Hoyer: When do you expect to implement these new performance standards?

Secretary Shalala: We expect to publish the Notice of Final Rulemaking in the Federal Register by September 30, 1996. We are providing a six-month phase-in period for grantees to begin implementing these standards. The standards are comprised in large part of current requirements which have received major updates and revisions for the first time in over 20 years. We do not expect that there will be serious obstacles to Head Start programs being able to implement the revised standards.

Mr. Hoyer: What technical assistance does the Department plan to provide to help local staff understand and use them?

Secretary Shalala: Through a nationwide network of Head Start training and technical assistance providers, the Department will support a comprehensive process to provide information on the revised standards to local program staff, parents and, as feasible, staff of collaborating community agencies which work in partnership with local Head Start programs. In order to be prepared for this undertaking, the Department will begin the process of "training the trainers" in June 1996.

Mr. Hoyer: Of the \$350 million increase requested, \$7 million is to improve the technical assistance system. Will this be used, in whole or in part, to support the implementation of the new performance standards?

Secretary Shalala: The provision of training and technical assistance to local programs regarding the performance standards will be incorporated as part of the overall Head Start training and technical assistance approach. As the training and technical assistance providers develop their work plans for the coming year, the Department will direct them to include this important work. The increased training and technical assistance funds will aid in these efforts.

Mr. Hoyer: I understand the Department is also developing outcome measures for use in Head Start programs. At what point in development are the new outcome measures?

Secretary Shalala: The Department has consulted widely in the early childhood and education communities and convened a technical work group of experts. This consultation led to a draft report which proposed an initial set of over 40 "performance measures" across all the domains of Head Start and also proposed revisions in existing data collection systems as well as the collection of new data. We are now in the process of reviewing that report, and plan to continue the development of the initial set of performance measures over the coming year.

Data related to some, but not all, of the proposed performance measures--such as measures of immunization rates and health outcomes--are currently available for each Head Start program. These measures can be used to stimulate program improvement and to supplement our monitoring of Head Start quality.

To move ahead as quickly as possible on the proposed measures for which data are not now readily available, we have created a unique partnership--called the Head Start Quality Research Centers--with four major academic institutions and Head Start grantees around the country to pilot approaches to the development of sound measures and the collection of data related to these measures.

The Quality Research Centers are located at (1) the Family & Child Care Research Program, Frank Porter Graham Development Center, at the University of North Carolina, Chapel Hill; (2) the High/Scope Educational Research Foundation in Ypsilanti, Michigan; (3) the Education Development Center, Inc. (a consortium of Harvard University, Boston College, and the Massachusetts Society for Prevention of Cruelty to Children) in Newton, Massachusetts; and (4) Georgia State University in Atlanta.

The Quality Research Centers will be piloting parent interviews in May and June 1996 designed to provide information on parents' perceptions of children's gains as a result of their Head Start experiences, program quality, and changes in parental behaviors. Child assessment instruments will be piloted by the Centers in the Fall of 1996.

Mr. Hoyer: How will they relate to the performance standards, the triennial review process, and program evaluations?

Secretary Shalala: The performance measures will supplement our other tools for ensuring that Head Start works for children: monitoring, research, and strong standards for quality programs. While the performance standards set goals and guidelines to which each local program must adhere, the performance measures will be used to assess the effectiveness and progress of the program nationally in producing beneficial outcomes for the children and families served. Data from a single time point could mislead us. We will need data over several years, and we will need to take the time to develop good measures and keep them up to date.

Mr. Hoyer: For many years, particularly in the 1980s, people measured the success of Head Start by the number of children it served and not by the quality of the services provided. Although I believe we ought to be serving all of the two million children eligible for Head Start, I also believe that quality is important. This belief was affirmed by the Administration and the Congress in the 1994 reauthorization. You have requested an increase of \$350 million for 1997, of which approximately half, or \$183 million, will be spent to increase enrollment by 40,000 children. Ninety eight million dollars is needed for cost of living adjustments and \$62 million will be spent for quality improvement awards. How was this allocation developed?

Secretary Shalala: We too share your concern about quality and the importance of assuring that all children enrolled in Head Start, regardless of the program in which they are being served, are being provided a high quality Head Start experience. We have acted to identify those grantees that are not providing services of acceptable quality and replace them with other sponsors. In fact, since October 1993, 40 Head Start grantees have either been terminated or have relinquished their Head Start grants. We have worked intensively with another 100 programs to correct problems that were identified. In addition to insisting on high quality performance, we have allotted almost \$445 million to grantees between 1992 and 1995 to give them the resources to improve program quality. These funds helped programs be more responsive to the needs of families by providing more full-day programs for low-income working families. They were also used to hire additional, much needed staff such as family workers to allow grantees to better work with and help Head Start families. In addition, quality improvement funds were used to assure that Head Start programs operate in safe and modern facilities, to increase supplies for Head Start classrooms and to upgrade equipment. Much of this funding was used to improve the salaries and fringe benefits of staff to allow Head Start programs to attract and retain quality employees. While Head Start staff continue to be relatively underpaid compared to many in similar positions, we believe that some real progress has been achieved in making Head Start salaries more competitive and, therefore, capable of attracting top notch people.

For FY 1997, we are proposing to continue this investment in quality through the key statutory set-asides: a set-aside of \$98 million to ensure that grantees receive cost of living increases, equal to the CPI increase; a set-aside for quality improvement allocations, equal to 25 percent of the remaining increase after awarding the COLA or \$62 million; and the T/TA set-aside of two percent of the proposed increase or \$7 million. We are proposing to use the remaining funds to increase enrollment by 40,000 because of the critical need to reach more children with these top quality services.

Mr. Hoyer: How do you balance the need to serve more children and the need to guarantee high program quality?

Secretary Shalala: Both goals are critically important. Head Start can only achieve its goals by providing high quality services--and we can only achieve our goals as a nation by providing these services to the more than one million eligible but unserved disadvantaged pre-school age children in this country. Shortly after taking office, I established an Advisory Committee on Head Start Quality and Expansion. Consistent with the Committee's recommendations, we invested much of Head Start's new resources during the last few years in quality. We believe that we have made substantial progress in this area, and now feel comfortable increasing the funds that are invested in serving additional children and families. We will, of course, continue to invest sufficient resources in quality to assure that the considerable gains that have been achieved in improving program quality are sustained and continued. It is our belief that the President's request strikes the appropriate balance between quality and expansion.

Mr. Hoyer: For many working families, affordable day care for infants and toddlers can be very difficult to find. The need for care for very young children is going to be increased still further as States across the country move forward with welfare reform. I am pleased to hear that the grants for the Early Head Start 0-3 program were awarded last spring. Could you give us a status report on the 0-3 program and its implementation?

Secretary Shalala: On March 17, 1995 we published in the Federal Register an announcement regarding the availability of funds to establish Early Head Start programs. We received over 580 applications in response to the announcement. After a thorough review process, including pre-award site visits, 68 applicants were selected to receive Early Head Start grants. The first months of many of the projects focused on planning, staffing, locating and preparing facilities and recruiting families. Thirty-nine of the grantees, however, had

previously operated infant and toddler programs with funding from the Head Start Bureau. These programs have served families from the beginning of their Early Head Start grants, and are modifying their programs to meet the comprehensive approach of Early Head Start defined in the four cornerstones of child development, family development, community building and staff development. By September 1996, over 5,000 families will be enrolled with approximately 7,000 children being served in this new program. In addition, 18,600 children are served through other Head Start infant and toddler programs for a total of 25,600 in FY 1997.

We have established a training and technical assistance network to assist the new grantees. The network combines new infant/toddler expertise with the established expertise available to grantees through the 16 Technical Assistance Support Centers and the 14 Resource Access Projects. A comprehensive orientation session was conducted in January for the 68 Early Head Start grantees as well as representatives of the training and technical assistance network, and site visits were made to assist the programs as they got under way. All programs will be participating in an intensive training session in June focusing on enhancing their skills and abilities in the infant/toddler development area.

As an important part of the design and implementation of the Early Head Start program, we have put in place a strong program of research and evaluation. In FY 1995, we awarded a contract to begin conducting a national longitudinal impact evaluation. And, in April 1996, we competitively selected 15 of the grantees to serve as local research sites, and to conduct research on the child, family, program and community variables that affect outcomes.

We are now proceeding with the planning for the expansion of the number of Early Head Start sites with FY 1996 funding. The competitive review process last spring yielded many more high quality proposals than we could fund at that time. Plans are now underway to select additional applicants for new funding. In

FY 1996 the funding for Early Head Start increases from three to four percent of the overall Head Start budget. We, therefore, expect to expand the program by \$35 million.

Mr. Hoyer: What are your plans for Early Head Start for 1997?

Secretary Shalala: Included in the President's request for FY 1997 is a \$14 million increase for Early Head Start. It will be used to support increased enrollment and to provide cost of living and quality increases to the programs.

Mr. Hoyer: Would you describe the review process which evaluates program quality for the Committee, which may not fully understand how indepth the review process is?

Secretary Shalala: The Head Start Act contains a requirement that each Head Start grantee receive a comprehensive on-site review of all program and fiscal requirements at least once every three years; therefore, approximately one-third of all grantees are monitored each fiscal year. The review is conducted by a team of non-Federal consultants under the leadership of one or more Federal staff members. In most instances, these consultants are Head Start program staff from States other than the one being monitored. Consultants may also be individuals who have worked with Head Start in the past and experts in the area that they are monitoring. Generally, these reviews occur over a four to five day period.

Head Start on-site monitoring reviews examine the grantee's ability to provide quality services consistent with current Head Start regulations for each component area: education, health, social services, parent involvement, services to children with disabilities, program and fiscal management and administration. Team members review program operations through a process of interviews, observations and record reviews using the On-Site Program Review Instrument (OSPRI). Interviews generally involve program staff, parents of children in the program, the parent policy group, agency board members and community collaboration partners in order to obtain the perspective of as many groups and individuals as possible. Observations are made of children's activities in the classrooms and may include observations of staff working with parents and children in the family's home in programs where home visits are an important part of service delivery. Team members work in partnership with the grantee to obtain a clear picture of how Head Start services are provided in the program being reviewed. Together, the program and the team work through what is needed to improve and strengthen the quality of the Head Start services provided in the community being reviewed.

Because the monitoring process uses a team approach, reviewers also share findings with other team members through a series of team meetings designed to provide a more complete and interconnected view of program services and to identify systemic and overarching strengths or concerns within the program. In the end, the team members provide the Federal team leader with a recommendation as to the program's compliance status with each of the program requirements reviewed. In addition, the team members may provide recommendations for improving the quality of program services in areas where improvement is warranted, including recommendations for future technical

assistance. If the team identifies deficiencies in the operation of the program, the grantee is notified in writing about the deficiencies and is asked to develop a "quality improvement plan" to correct them. Grantees must correct all deficiencies within 1 year of being notified about them.

Mr. Hoyer: How do you evaluate the effectiveness of regional offices?

Secretary Shalala: Each Regional Administrator has a performance agreement with the Assistant Secretary that covers a range of critical outcomes, including the Head Start monitoring, quality improvement and partnership activities. The Assistant Secretary reviews performance on these plans regularly during the year.

Mr. Hoyer: How do you monitor regional office evaluations of local programs?

Secretary Shalala: We use several different techniques to monitor regional evaluations. First, using a national database that contains monitoring results from each review, ACYF reviews individual grantee findings as well as aggregated information from each Region, in order to determine patterns of compliance and non-compliance across Regions. Second, ACYF is currently engaged in a comprehensive effort to rethink and strengthen the monitoring system. A key part of this process has been the convening of a series of focus groups in each Region. The Focus group participants include local program staff who have been review team members as well as recipients of the review process in their own program. They provided an opportunity to hear from programs about what in the current monitoring system works and what needs to be changed. They also provided ACYF with insights into the monitoring practices of each Region. Third, we conduct regular conference calls among regional office staff to discuss and strengthen monitoring practices.

Mr. Hoyer: How do you maintain consistency in monitoring programs over an extended period of time, given the turnover in program specialists?

Secretary Shalala: The Head Start Bureau, along with Federal staff in the Regional Offices, have been working to establish a consistent approach to monitoring and a consistent understanding of the regulations that are addressed during the review process. Several activities have focused on these issues. Two internal workgroups, composed of representatives from the Bureau and each Region, are addressing aspects of monitoring. One group is working to improve the basic monitoring process. The other is addressing special tasks associated with implementing new provisions contained in the Head Start Act regarding the identification of deficiencies during the review process and the corrective action steps that are taken following the review to address these deficiencies. In addition to the workgroups, regular conference calls between the Bureau and the Regions are conducted to discuss implementation issues related to monitoring, the interpretation of the regulations and the actions taken to address deficiencies. In September 1995, the Bureau convened a meeting of Federal Head Start managers in the Regions as well as those who serve as team leaders on reviews to address

the quality of the monitoring effort. This was the first national meeting of Federal staff that focused exclusively on the important task of Head Start monitoring. Collectively, the participants developed a set of practices that each team leader is expected to implement during and following a monitoring review. These activities should help to minimize the disruptions that could result from the turnover in program specialists which some Regions are experiencing.

Mr. Hoyer: How do you ensure consistency of evaluations of one program from year to year, and consistency of evaluations within regions and across regions?

Secretary Shalala: As described in the response to the above question, the Head Start Bureau and the Regional Offices are working to ensure consistency within and across Regions in the monitoring process and in the understanding and interpretation of the regulations addressed during monitoring. Key efforts include the two internal workgroups composed of representatives from the Bureau and each Region which are addressing aspects of monitoring; and the ongoing conference calls between the Bureau and the Regions to address implementation issues related to monitoring, the interpretation of regulations, and the corrective actions taken to address deficiencies. Additionally, in September 1995, Head Start convened a meeting of Head Start managers in the Regions as well as program specialists who serve as team leaders on reviews to address issues related to the consistency and quality of the monitoring effort. Collectively, the participants developed a set of practices which each team leader is expected to implement during and following the monitoring process. One practice emphasized this year has been cross-Regional participation on review teams. Both Federal team leaders as well as consultant review team members have participated on reviews in other Regions in order to share practices and to identify areas of consistency that need further work. To address consistency, most Regions have implemented the practice of Regional staff debriefings with program specialists following each review to discuss the findings and decisions regarding non-compliance and deficiencies. This enables Regional staff to develop a common understanding of the regulations and how they are interpreted as well as how decisions get made regarding deficiencies. We also expect that the current effort to rethink and strengthen the monitoring system, as discussed above, will identify other ways ACYF can address monitoring consistency within and across the Regions.

Mr. Hoyer: While Head Start serves approximately 40% of eligible children, studies show that as few as five percent of homeless children are in any kind of Head Start or day care program at all. Homeless children are difficult and expensive to serve for any program, including Head Start, but are in particularly great need of the health, education and social services Head Start provides. A demonstration program which funded 14 grantees across the country to focus on the needs of homeless children expired in 1995. I was pleased that the Department renewed these grants in 1996. Do you plan to continue these services to homeless children in 1997, either through these 14 grantees or some other programs?

Secretary Shalala: We have been very pleased with the quality of the services provided by the 14 homeless demonstration grantees. We agree with you that these families are among the country's most disadvantaged and needy families, and we want to continue helping them through the Head Start program. We are currently reviewing the most appropriate ways to assure that Head Start reaches out to serve some of these most disadvantaged families.

Mr. Hoyer: Do you plan to expand these services at all?

Secretary Shalala: As part of our consideration of how Head Start can best meet the needs of homeless children and families, we will be reviewing what level of funding support would be appropriate. If the President's request is approved by the Congress it would, of course, provide us with sufficient resources to expand our efforts in this area and such an expansion would be given careful consideration.

MEDICAID PROVISIONS

Mr. Hoyer: As you know, two provisions have been inserted in the tentative conference agreement that would give Medicaid windfalls of \$46 million and something between \$300 million and \$1.2 billion to the Republican Governors of New Hampshire and Louisiana, respectively. I understand that your Department determined that the New Hampshire provision could also result in claims from New Jersey, Illinois, Minnesota and D.C. I also understand that the Congressional Budget Office has scored these provisions as having no impact on the budget. I must admit I fail to understand how the Governors believe this provision is going to add millions to their State budgets while the CBO claims the same provision won't cost the Federal Government anything. Could you describe the impact of these provisions and the precedent they establish?

Secretary Shalala: Both of these provisions would result in States receiving more federal funds than they would under current law. As you know, many States have tight budgets made even tighter by trying to meet the growing costs of providing health care services through Medicaid, and Louisiana and New Hampshire are among them.

The first provision essentially holds States harmless for disproportionate share (DSH) payments that they inappropriately made to Mental Hospitals during 1994-1995. We understand that the purpose of the provision is to help New Hampshire since we notified the State of our intent to disallow these payments on March 11. However, as the amendment is drafted, other States could benefit, as well. This provision prevents us from enforcing the Medicaid rules and regulations. The provision is capped at \$54 million. CBO, however scored the provision with increased Federal costs of \$50 million.

The second provision caps the Federal share of Medicaid spending in Louisiana at \$2.622 billion annually through FY 1999 while reducing the State's relative share of Medicaid spending during that period. The amendment allows the State to reduce its funding obligation for the Medicaid program by one-third. Louisiana's Federal match rate for FY 1996 would be increased from just under 72 percent to over 84 percent. CBO scored this provision as costing zero in FY 1996, but \$900 million through FY 1999. A more recent Departmental estimate indicates that the amendment would result in additional Federal costs of \$260 million in FY 1996, and a total of \$620 million through FY 1999.

OPERATION RESTORE TRUST

Mr. Hoyer: I understand that the Office of the Inspector General, in cooperation with HCFA, the Administration on Aging, the Department of Justice, and state and private sector representatives, is undertaking Operation Restore Trust to target Medicare and Medicaid fraud and abuse in the states where that abuse is highest. I applaud this initiative. What are your goals for this effort?

Secretary Shalala: The Operation Restore Trust (ORT) two-year project began May 3, 1995. ORT is a partnership of Federal and State agencies working together to protect the health care trust funds more effectively through shared intelligence and coordinated enforcement, and to enhance the quality of care for the programs' beneficiaries. The project has initially targeted fraud and abuse in nursing facilities (including hospices), home health agencies, and durable medical equipment in five States (New York, Florida, Illinois, Texas, and California).

The ORT mission is to more effectively utilize resources currently devoted to combating health care fraud and abuse. Greater collaboration between Federal, state, and local agencies responsible for the integrity of the Medicare and Medicaid programs should result in improved identification and prosecution of health care fraud as well as greater identification and correction of programmatic weaknesses that lead to abuse and waste.

Specific objectives of ORT are:

- ▶ Resolve problems of non-compliance
- ▶ Investigate instances of fraud
- ▶ Involve the public and industry
- ▶ Initiate Voluntary Disclosure Pilot Program
- ▶ Promote efficiency and effectiveness

OPERATION RESTORE TRUST

Mr. Hoyer: By what percentage do you expect to reduce fraud and abuse?

Secretary Shalala: It is highly unlikely that we will ever be able to pinpoint the amount of fraud and abuse that currently exists in the Medicare and Medicaid programs. A few years ago, the General Accounting Office (GAO) attempted to estimate the amount of fraud and abuse in all health care programs. GAO issued a report detailing their analysis which produced an estimate of 10% fraud and abuse in all health care programs. But really this estimate is a "best guess" of a number of different experts based on a wide variety of experience and research in this area. As a result, it is virtually impossible to establish some kind of baseline, from which we can expect to produce a percentage reduction. In fact, what is likely is that it will seem, on the surface, that more fraud and abuse is occurring--because we are focusing our efforts and collaborating in the ways just described, with the result that more cases are being opened, more audits are being conducted, and more analysis to identify wasteful practices is taking place.

We assess our bottom line in this project in the following way. Project ORT is targeting five states which contain 38% of all Medicare payments (FY 1994--\$61.1 billion) and 41% of all Medicaid payments (FY 1994--\$41.4 billion) in the United States. For every dollar we spend on this program, we expect the Medicare and Medicaid programs to save six to eight dollars in reduced spending on wasteful practices and court awards from fraud cases.

In addition to identifying and penalizing those who willingly defraud the government, ORT is designed to alert the public and industry to fraud schemes and to identify and correct vulnerabilities in both programs.

TOLL-FREE HOTLINE

Mr. Hoyer: When I go to town meetings, senior citizens often recommend to me that HCFA establish a telephone line to report overcharges on Medicare and Medicaid bills. I know that HCFA has already established such a line. What is being done to publicize that number?

Secretary Shalala: Toll-free numbers already appear on Medicare benefits notices and are published in all telephone directories for the areas for which carriers have claims processing jurisdiction. The numbers also appear on benefits notices generated to beneficiaries and other publications; e.g., beneficiary newsletters from carriers, material produced by Information, Counseling, and Assistance (ICA) grantees.

Mr. Hoyer: How many calls do you receive?

Secretary Shalala: In FY 1995, the carriers received 15,156,687 telephone calls from beneficiaries. It can be presumed that most of these were on the toll-free lines.

Mr. Hoyer: How much money has it saved?

Secretary Shalala: Medicare toll-free lines do not save money per se, but are a service provided to our beneficiaries. Currently, HCFA receives funding to support toll-free lines for all Medicare beneficiaries. If the toll-free lines were discontinued, our beneficiaries would be forced into making long distance calls at their own expense, prepare written inquiries, which are more expensive to process, or walk-in to one of our 29 Medicare carriers. Furthermore, with the implementation of the Medicare Transaction System, it is conceivable that there will be fewer locations available to accept walk-in inquiries.

Mr. Hoyer: What could be done to further publicize its availability?

Secretary Shalala: Based on the widespread availability of toll-free lines, it is not necessary to further publicize their availability. As previously stated, toll-free numbers already appear on Medicare benefits notices and are published in all telephone directories for the areas for which carriers have claims processing jurisdiction. The numbers also appear on benefits notices generated to beneficiaries and other publications; e.g., beneficiary newsletters from carriers, material produced by Information, Counseling, and Assistance (ICA) grantees.

Mr. Hoyer: Would it be possible to print the telephone number at the bottom of every statement of charges to Medicare or Medicaid so seniors have the number available when they receive that statement?

Secretary Shalala: Toll-free numbers already appear on Medicare benefits notices.

TUESDAY, APRIL 30, 1996.

HEALTH CARE FINANCING ADMINISTRATION

WITNESSES

BRUCE C. VLADECK, ADMINISTRATOR

LEE MOSEDALE, DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT

DENNIS P. WILLIAMS, DEPUTY ASSISTANT SECRETARY FOR BUDGET,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTRODUCTION OF WITNESSES

Mr. WICKER. The hearing will come to order. We have with us today Bruce C. Vladeck, administrator of the Health Care Financing Administration. We're delighted to have you, Mr. Vladeck.

Mr. VLADECK. Thank you very much, Mr. Wicker. I am accompanied today by Lee Mosedale, who is our director of Financial Management, and by Dennis Williams, who I believe you probably will see a fair amount of in these weeks, who is from the Office of Management and Budget in the Department of Health and Human Services. Between the two of them, I hope I'm able to answer any questions you might have.

OPENING STATEMENT

We submitted a statement to the Committee, Mr. Chairman, and given today's schedule, I will try not to go through all of it in detail for you. If I may just hit a few highlights about our budget request for fiscal year 1997, I'll do so as quickly as I can and then, leave as much time as possible for your questions and those of the other Members.

Let me begin by saying that we in the Health Care Financing Administration are proud of the efforts we have made over the last number of years to adopt the principles of providing better service for fewer dollars and for managing our programs as efficiently as possible. We have two major objectives. First is careful stewardship of the tax dollars entrusted to us. The second is the assurance that Medicare and Medicaid beneficiaries have access to the best possible care when they need it.

We are very much a workload-driven agency and a workload driven organization. Much of our budget request for fiscal year 1997 reflects the continuing increases in our responsibility because of the continuing growth in the number of people covered by our programs and the concomitant activities that are required to assure them the benefits which they receive. Our first chart over here reflects the continuing growth in the number of beneficiaries HCFA serves. We are running at a rate of increase in Medicare beneficiaries of approximately 1.8 percent per year. That number holds pretty reliably throughout the six-year budget window, as well as

the year-to-year increase. We have, in recent years, experienced increases of as much as 4 percent per year in the number of Medicaid beneficiaries. We expect to see some slight diminution in that growth rate over the coming years. But nonetheless, we are serving more people every year.

In total, in fiscal year 1997, we expect that Medicare and Medicaid will provide health care to 72 million beneficiaries. That is a number that has increased approximately 16 percent over the past five years. Our total expenditures are estimated to be \$319 billion. But again, in workload terms, let me just suggest that the total number of Medicare and Medicaid beneficiaries in 1997 will equal the combined populations of Illinois, Florida, Texas, Michigan, Massachusetts, New Jersey, Arizona, and Nevada.

ADMINISTERING LARGE ENTITLEMENT PROGRAMS

This is an attempt to display graphically without either inaccuracy or creating any confusion the fact that we are now in the President's 1997 budget proposal talking about less than 1 percent of total Medicare and Medicaid expenditures being expended to operate the two programs. If the whole blue circle represents the size of those two programs, the little dot in the middle represents HCFA's operating budget. And if you then go to the pie chart in the lower right-hand corner, you will see that fully 73 percent of HCFA's operating budget, in fact, is our payments to Medicare contractors who pay claims, who do program integrity functions, who do medical review of bills, and who provide services to providers and beneficiaries in the Medicare program. An additional 8 percent of that 1 percent is spent on State certification for the inspection and assurance of quality of health care facilities. The actual HCFA program management budget is only 16 percent of that 1 percent, or approximately \$350 million in the President's budget request.

Another way of explaining the leverage associated with this budget is to look at our prominent inverted pyramid. HCFA has a total head count of approximately 4,100 employees, of whom just under 2,700 are at central office in Baltimore and Washington, and 1,400 are in our regional offices throughout the United States. The activities of those 4,100 people provide services to 72 million beneficiaries through about 65,000 other folks who are our direct partners in State Medicaid agencies, State survey and certification agencies, in the PROs, and in the Medicare contractors. Of course, the services are delivered directly by close to a million providers, including 600,000 physicians, 6,500 hospitals, 150,000 laboratories, and other personnel.

GROWTH RATES IN MANDATORY AND DISCRETIONARY SPENDING

The last chart I have is just another way of reflecting some of these underlying realities in our budget. We'll skip the managed care growth chart in the interest of time. The green line represents total outlays in the program. These are expressed in terms of accumulative percentage since fiscal year 1993. The blue line, next down, represents the number of Medicare claims we will process even as Medicare managed care grows. Claims volume is leveling off, but it is still projected to grow by about 3 percent in 1997. Program management is the line immediately above zero, which re-

flects the expenses of actually operating these programs. The number of FTEs within HCFA is the line below the zero growth rate.

Very quickly, let me just identify several priority issues for us in the budget request for fiscal year 1997. The first is our continued emphasis and our continued focus on program integrity issues. The President, as you know, as part of his budget has proposed the Medicare Benefit Integrity System to make available trust fund funds in a continuing renewed basis to support expanded program integrity activities, and would provide us with an additional \$104 million for those activities from a fixed trust fund allocation for 1997 and thereafter.

The fiscal year 1997 budget request also includes, largely offset by other expenses on the contractor budget, funding for continued implementation of the Medicare Transaction System, a new data processing system which will replace the 60 different processing sites at which, using 9 separate sets of software, our contractors now process Medicare claims with a single integrated real-time national data processing system. We estimate it will produce administrative savings on the order of \$200 million a year beginning in the year 2000 when MTS is fully operational and in each subsequent year thereafter.

Finally, many of the budget requests include expenses associated with the growth of managed care in both the Medicare and Medicaid populations. The Medicare managed care enrollment is growing at a compounded rate of approximately 2 percent per month and has been over the last two years or so. Medicaid managed care enrollments are actually growing more quickly than that, providing considerable benefits to beneficiaries, and over time we hope, some cost-savings associated with that growth. Growth creates for us new responsibilities in developing and implementing better mechanisms for monitoring the performance and quality of care of managed care plans. New responsibilities also include giving beneficiaries the kind of information they need in order to make informed choices about their insurance options and about choices between plans.

In very rapid summary, HCFA is the largest purchaser of health care in the world. In terms of most measures of productivity and output, we have been bringing our basic costs of operating these programs down pretty consistently over the last half dozen years. But we do have basic obligations to protect our beneficiaries and the programs that provide them with these services. In that regard, we believe the very modest request we have made for fiscal year 1997 is the minimum necessary to continue to maintain that level of service for beneficiaries within the constraints of operating in as fiscally careful a way as we can.

I thank you very much for the opportunity to be here. Obviously, I am pleased to respond to any questions you might have.

[The prepared statement of Mr. Bruce Vladeck follows:]

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present the fiscal year (FY) 1997 budget request of the Health Care Financing Administration (HCFA).

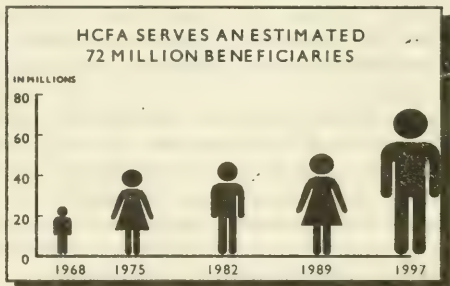
Nowhere in the Administration are we more keenly aware of the demanding budgetary environment in which the Federal Government currently operates than we are here at HCFA. We are a workload-driven agency. We cannot opt to enroll fewer beneficiaries, pay fewer claims, or restrict access by certifying fewer health care facilities. "Doing more, with less" is not just a motto, it's a necessity. Given this environment, I am proud to present this highly disciplined budget which focuses on HCFA's two guiding principles: careful stewardship of the tax dollars used to serve our beneficiaries; and assurance that Medicare and Medicaid beneficiaries have access to the best possible care when they need it.

Before I speak about the specifics of our request, I would like to put the programs administered by our agency in perspective. HCFA is the largest purchaser of health care in the world. In FY 1997, the Medicare and Medicaid programs will spend about \$319 billion to provide essential health care to 72 million beneficiaries, a number which has grown by 11 million since 1992. To give you an idea of how many Americans our agency actively serves, the total number of Medicare and Medicaid beneficiaries is equal to the combined populations of Illinois, Florida, Texas, Michigan, Massachusetts, New Jersey, Arizona, and Nevada.

\$319 billion is a lot of money. But it is money spent well and money spent efficiently. Where does this money go? Primarily, it goes to the tens of thousands of Americans working in various settings to provide health care to the elderly, disabled, and disadvantaged. For example, this year, more than \$50 billion in Medicare and Medicaid benefit payments will be made to 600,000 physicians and other practitioners, over \$35 billion in payments will be made to more than 16,000 nursing homes, and over \$115 billion in payments will be made to 6,500 hospitals, including 719 sole community hospitals which provide vital health services to rural communities.

Additional Medicare and Medicaid payments totaling over \$100 billion will be made to thousands of other American providers and suppliers of medical goods and services.

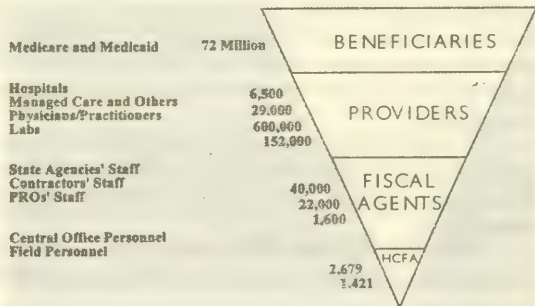
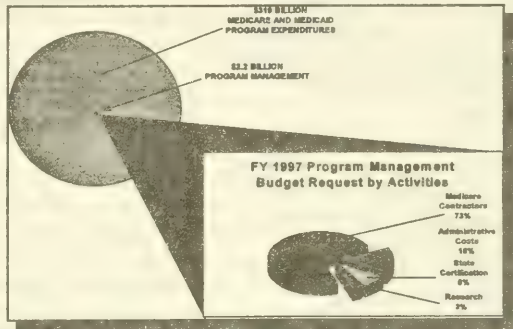
Despite the size of these programs and the tremendous impact they have on the health and well-being of both tens of millions



of Americans and the U.S. economy, the Health Care Financing Administration is NOT a large, centralized bureaucracy. In fact, HCFA's administration of the Medicare and Medicaid programs is an exemplar of public/private partnership and administrative flexibility, efficiency, and effectiveness. HCFA's FY 1997 Program Management request of \$2.2 billion represents

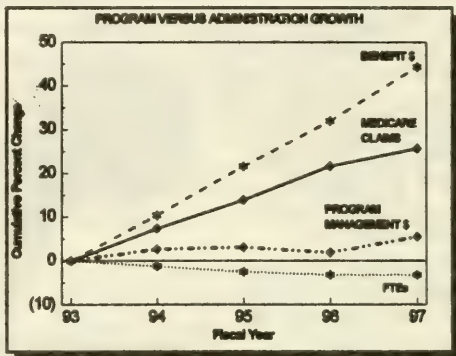
less than one percent of total program outlays. 73 percent of that \$2.2 billion will go to 77 private sector contractors, employing 22,000 people, located throughout the United States who process the 860 million bills submitted by physicians, hospitals, and other health care providers for the care given to Medicare beneficiaries. Eight percent of the \$2.2 billion will go to State survey agencies employing 2,200 people inspecting hospitals, nursing homes, home health agencies, and other health care providers to ensure compliance with essential statutory health and safety requirements, which I might add, benefit all Americans.

Of our \$2.2 billion program management request, only \$359 million, or about 1/10 of 1 percent of total projected program outlays, is to pay for Federal employees and activities. This \$359 million supports HCFA's 4,100 employees, who communicate every day with beneficiaries and providers, contract with Medicare intermediaries and carriers, develop more efficient operating systems, determine ways to improve the quality of health care, manage programs to fight fraud, waste, and abuse, assist States with Medicaid issues, implement legislation, and provide actuarial, technical, and information assistance to the Congress and other public and private entities.



As I mentioned earlier, we understand the demanding budget environment in which the Federal Government now operates. Given the broad reach and substantial role of the Medicare and Medicaid programs in the daily life of so many Americans, I am proud of HCFA's progressive use of Federal, private, and State partnerships as well as our sparing use of Federal tax dollars to deliver health care efficiently and effectively.

As I mentioned before, HCFA's two guiding priorities are: careful stewardship of the tax dollars used to deliver services to Medicare and Medicaid beneficiaries, and assurance that Medicare and Medicaid beneficiaries have access to the best possible care when they need it. I would now like to talk about some of the exciting initiatives that will enable us to achieve these goals.



FOCUS ON STEWARDSHIP

While providing health care security for Medicare and Medicaid beneficiaries we realize we also have a responsibility to protect taxpayer dollars. We take our stewardship obligation seriously and will continue to be vigilant in this very important role.

Although health care expenditures have increased at a rapid rate due to the aging of the population, increasing numbers of disabled beneficiaries, a proliferation of providers and other factors, HCFA has achieved efficiencies which have enabled us to hold program management costs virtually level in nominal dollars. Let me emphasize, however, that our search for increased efficiencies is becoming more difficult each year as our beneficiary population swells and our workloads continue to increase and become more complex.

Perhaps the best example of the many efforts we are undertaking to improve our operations and maximize efficiency is the Medicare Transaction System, or MTS. With MTS we are entering a new era of highly efficient claims processing and information management.

MTS will consolidate claims processing currently performed by 77 contractors, 9 shared systems and 60 processing sites into a single, standard claims processing system.

We estimate the investment in MTS will produce \$200 million in administrative savings annually when fully operational in the year 2000.

The importance we place on our stewardship responsibility is also apparent in our efforts to detect and deter fraud, waste and abuse within our programs. For example, we are playing a major role in Operation Restore Trust. Within this initiative, HCFA, along with the HHS Office of Inspector General, the Administration on Aging, the Department of Justice and other agencies, is undertaking a team effort in combating Medicare and Medicaid fraud, waste and abuse. This initiative is focusing on skilled nursing facilities, home health agencies, hospices, and durable medical equipment suppliers in the five States with the largest beneficiary populations (New York, Florida, Texas, Illinois and California.)

At present, funding for HCFA's program integrity activities is subject to the variability of the budget process making it difficult for HCFA to invest in innovative strategies to control fraud and abuse. In order to stabilize funding and accelerate HCFA's efforts against fraud and abuse the President has proposed implementing the Medicare Benefit Integrity System, or MBIS. MBIS will establish a dependable and permanent source of funding for our anti-fraud and abuse activities by supporting them through the Medicare Trust Funds.

MTS will also improve HCFA's capability to detect fraud and abuse by identifying suspicious and aberrant billing patterns, facilitating early trend detection, and allowing us to take action to prevent payment for inappropriate claims.

In addition to these efforts, HCFA has entered into a partnership with the Los Alamos National Laboratories in order to utilize highly sophisticated data analysis techniques to detect, deter and prevent fraud and abuse.

These initiatives are in addition to our ongoing payment safeguard activities, which return \$14 for every dollar invested. As the President pointed out in his State of the Union message, HCFA's program integrity efforts have resulted in \$15 billion in savings over the last 3 years. Through these and other activities, we will continue to aggressively pursue the prevention, early detection, and prosecution of fraud and abuse in order to ensure program integrity and protect taxpayer money.

FOCUS ON THE BENEFICIARY

As seriously as we take our stewardship responsibilities, we have an even more fundamental obligation to focus on our 72 million beneficiaries—the elderly, disabled, and disadvantaged persons for whom the Medicare and Medicaid programs were created. From the beneficiaries' prominent roles in our mission and vision statements to the execution of our most mundane daily tasks, all of our activities are dedicated to the principle of serving the beneficiary.

Our emphasis on the beneficiary has many practical applications. For instance, our beneficiaries are our staunchest allies in the war against fraud, waste, and abuse. Countless beneficiaries scrutinize their explanation of benefits notices line item by line item to ensure that precious program dollars do not go to waste. Beneficiaries, better than anyone else, understand how vital the Medicare and Medicaid programs are to the health and well-being of many Americans.

It's also clear that better-informed beneficiaries make better payment plan, provider, and treatment choices. Tens of thousands of Medicare beneficiaries join managed care plans each month. However, we believe that a lack of information deters many more from choosing this option. Therefore, it is vitally important that we provide the information necessary for beneficiaries to make appropriate and informed health care choices. That's why we are continually reexamining how we and our partners interact with our beneficiaries, looking for better and more creative ways to communicate with them.

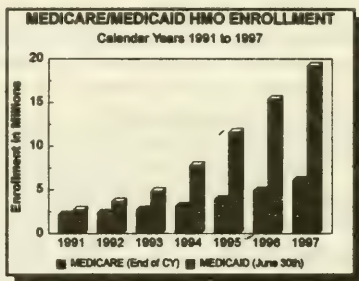
Toward that end, this budget allows HCFA to provide a *Medicare Handbook* to all Medicare beneficiaries, ensuring they have the most current information on all aspects of the program.

But communication is a two-way street. That's why HCFA has established hot-lines to answer inquiries from Medicare and Medicaid beneficiaries. That's why we routinely meet with beneficiary and special interest groups. And that's why we are preparing for the future with HCFA On-Line, a comprehensive communications strategy designed to allow us to listen and respond to the information needs of our beneficiaries and our other customers with accuracy, speed, and flexibility.

Our communications capabilities will assume greater importance in the coming years as we strive to promote informed health care choices while we also seek to expand the array of health care options available to our beneficiaries.

As a leader in America's evolving health care system, HCFA is continually searching for ways to improve beneficiary access to care, to make our current payment systems more efficient, and to develop alternative health care delivery systems.

For example, through implementation of telemedicine demonstrations in four States, HCFA seeks to improve access in rural areas while collecting information that will lead to a payment policy that integrates the increasing capabilities of telemedicine into the



Medicare program. Through the Medicare Choices demonstration, tens of thousands of beneficiaries will have access to a much broader range of managed health care plan options than are available under current law. These options include preferred provider organizations, provider-service networks, open-ended HMOs, integrated delivery systems, and primary care case management. Finally, through cooperation with HCFA on the use of Statewide Section 1115 Medicaid demonstration waivers, 12 States are implementing innovative, cost effective, managed care delivery systems, resulting in the provision of coverage to 2.2 million persons who were previously uninsured.

Expanding access to care, and finding more cost efficient ways of paying for it, are meaningful only if we are purchasing quality services that improve the health status of our beneficiaries. HCFA continues to reengineer our quality assurance functions to promote improved quality of health care services and to emphasize beneficiary-focused outcome measures.

I am very pleased to report that we are nearing completion of revised, patient-centered, outcome-oriented provider requirements that include a central focus on quality assessment and performance improvement programs, and reduce the current emphasis on paperwork compliance. These revised requirements are complemented by new surveyor processes which focus on the actual experiences of beneficiaries in nursing homes, home health agencies, dialysis facilities, and facilities for persons with mental retardation.

Our Health Care Quality Improvement Program is a proactive effort that develops and promotes best practice guidelines, utilizing an educational approach in partnership with the health care community that results in improved quality of care not just for Medicare beneficiaries, but for all Americans.

I think you can see from the depth and breadth of these activities, from the way we interact with our beneficiaries, carry out our role as a leader in the health care evolution, and go about our quality assurance activities, at HCFA, we focus on the beneficiary.

CONCLUSION

In summary, as the largest purchaser of health care in the world, HCFA is dedicated to providing the highest quality of health care as efficiently as possible. Amidst the budget debate, I ask you to remember the programs and the people who rely on them to support their health care needs. This budget request is in line with the two basic objectives of the President's budget: "it helps protect the most vulnerable Americans, including senior citizens, working families, and children" and at the same time reflects restraint and improved efficiencies consistent with achieving a balanced Federal budget in 7 years.

Thank you very much for the opportunity to present HCFA's budget. I look forward to working with the Committee and I would be happy to respond to any questions or suggestions you may have.

ACTUARIES' TRUST FUND PROJECTIONS

Mr. WICKER. Thank you, Dr. Vladeck. Let me begin by asking about the Medicare program. As you know, yesterday an article appeared saying that the Congressional Budget Office [CBO] now estimates the Medicare Trust Fund will be bankrupt by the year 2001, one year earlier than previously predicted. Do you expect the trustees to come to a similar conclusion in their report next month?

Mr. VLADECK. I am always reluctant to predict what our actuaries will tell us until they tell us, and they have not completed their work. But we have looked at the CBO report in a very initial way—because it was just released, I guess, over the weekend. While we don't know yet whether it will conform to the projections of our actuaries, and while we always have some items that CBO does that we would do differently, we don't have any major quarrel with the numbers that are presented by CBO.

We're talking now about a difference from last year's report to this year's report on 75-year projections, which is what our actuaries do, of one year. These are very small differences, and they will be somewhere in between, I would expect. But until we actually get the numbers from the actuaries, that's probably the best I could give you as an estimate.

Mr. WICKER. So you acknowledge that there will be higher-than-expected outlays from the trust fund?

Mr. VLADECK. Well, we've already reported through March of this calendar year that outlays had been running higher than was predicted in last year's trustees' report. That has already been reported and incorporated into the President's budget estimate.

Mr. WICKER. Would you comment as to the reason for that?

Mr. VLADECK. Well, there are two reasons. The less important of the two reasons seems to be that, for all of the Social Security programs, payroll revenues have been growing less quickly than the actuaries estimated they would in 1995. I think CBO also refined its revenue estimates downwards. That is a sort of macro-economic phenomenon that's over my head. I think it has something to do with the amount of economic growth that's going to wages. That's about a quarter to a third of the error in estimation on the status of the Hospital Insurance Trust Fund.

The major reason for the higher expenditures than estimated is associated with higher outlays for inpatient hospital care. That seems to have two parts to it. One is Medicare beneficiaries are using hospitals more than we had predicted they would in early 1995, and their cases seem to be more complex and more costly per admission than we had projected. How much of that is attributable to new technologies, how much of that is attributable to epidemiological patterns associated with the continued aging of the Medicare population, how much of that is associated with changes in hospital behaviors as they respond to financial pressures from both the public and private sectors, we don't know yet. We've met with the staff of some of your colleagues on some of the other committees to try to work with them to disentangle it. Our actuaries are spending a lot of time trying to understand it. We have had extensive discussions with the American Hospital Association. Hospital utilization in the Medicare population is not falling as quickly as

it is for other parts of the population, and we still don't fully understand why.

TRUST FUND SOLVENCY

Mr. WICKER. Mr. Vladeck, are you alarmed by this new statistic? Do you agree that there is a very, very serious problem we're facing right after the turn of the century with the Medicare trust fund?

Mr. VLADECK. We absolutely agree. We have been saying that certainly since I assumed this position in 1993. The 1993 trustees' report pointed with considerable concern to the status of the trust fund and called for immediate action by the Congress. The 1994 report was actually slightly more optimistic than the 1993 report, but it still emphasized both the intermediate and the long-term problems. The 1995 report essentially said that in 1993 and 1994 we had called for action on the trust fund, on the Medicare program in the context of broader health reform. The report also stated that while the trustees were still committed to broader health reform, they didn't necessarily believe that the Medicare program could wait in terms of some of the changes that were necessary.

My sense is that my state of alarm about the status of this has been high for three years. I don't believe the current numbers say very much more than what we had already known and had already been trying to communicate.

NATIONAL GOVERNORS' ASSOCIATION MEDICAID PROPOSAL

Mr. WICKER. Let me shift then to Medicaid and ask you, if you will, to compare the administration's 1997 Medicaid proposal to that of the Nation's governors.

Mr. VLADECK. I believe, Mr. Chairman, that there is some uncertainty still as to some of the specifics about how one would translate into specific legislation the agreement that the National Governors' Association endorsed. And that particularly relates to two items: one is the extent to which the current legal structure of the program would be maintained or entirely eliminated; and second, the way in which growth in State costs in excess of what was anticipated would be accommodated for. The so-called umbrella fund in the Governors' Association proposal can be interpreted as working in a way very similar to the per capita cap that is proposed in the President's budget. On the other hand, it can also be interpreted as imposing an absolute cap on total Federal Medicaid liabilities, in which case it would be fundamentally different from the President's budget.

The President's budget also does not contain the reduction in State-matching rate requirements that are contained in the Governors' proposal, nor does it repeal existing Federal legislation on provider taxes and donations. So, the proportion of Federal and State expenditures that would be produced under the NGA proposal, we believe, may be quite different from the President's budget. But some of those details are still, as I understand it, being discussed. In the course of the discussion, some of the initial concerns we had about benefits and about enforceability in benefits and so forth in the Governors' discussion appear to be moving in the direction of the President's proposal. But, again, there are still some areas of considerable uncertainty as I understand it.

Mr. WICKER. Thank you. I've taken a little more than five minutes. Mr. Miller, are you ready to proceed with questions?

TRUST FUND DEFICITS

Mr. MILLER. Thank you, Mr. Chairman. Mr. Vladeck. Let me proceed a little bit with the Medicare issue some more, since that's been in the news again this week, as it was last week, about the impending bankruptcy and how serious a problem it is. One table shows that ten years from today we will have a \$440 billion deficit in the Medicare program. The real problem, as you well know, is the demographic hit that comes along here at about 2010 or so. If we're hitting a \$400 billion deficit in 2006, it's going to obviously totally blow up then. So we all agree we've got to do something; there's total agreement on that issue. I think that we have to save the Medicare system and slowing the rate of growth is the way we do it basically.

Right now the rhetoric is so partisan. It is very unfortunate. I know you're not doing the ads by the AFL-CIO, but there are ads out there now that just make it almost impossible to have serious discussions on the issue. The ads are scare tactics when we need to really be very bipartisan on this issue. We can have differences on how to go about it, but the scare campaign is kind of sad right now for seniors. I've got more seniors in my district than anybody; so I hear about it. Do you have any comment about that? The scare tactics are really unfortunate because nobody wants to have Medicare destroyed, and the amount of money that we're talking about between what you are proposing and what we're proposing is within 2 percentage points, over a seven-year period. So money is not the real issue.

NEGOTIATIONS ON REFORM PROPOSALS

Mr. VLADECK. I will try to forego any discussions of who struck John or similar terms, but answer in the spirit of your question, Mr. Miller, and just tell you that I had the privilege of participating in a very limited way in some of the budget discussions that went over New Year's weekend that included the President and the congressional leadership and some of the other executive branch leadership. I was of the opinion at the time that the opportunities for agreement were very substantial. We actually did not get to a level of detail in those discussions that would have permitted one to say an agreement was imminent, but there were some very extensive discussions of the issue. There was a very extensive interchange down to a level of detail that was really quite remarkable. I felt, at the time, that a process was well underway that could very well produce an agreement, certainly on the Medicare issues. I've always been less sanguine about the opportunities for agreement on Medicaid because I think some of the philosophical differences are more profound.

I must say that, relative to the Medicare issues, the major divisions, at least as appeared to be the case at that point in the overall budget discussions, were not primarily about dollar issues. They were about policy issues and, for want of a better word, philosophical issues about the shape and administration of the program, the relative responsibility of beneficiaries and providers and so forth.

But, again, to a very limited participant, it appeared to me at the time, that there was an opportunity for a compromise and an agreement to be reached. Those discussions were obviously taking place in a broader context. Discussions were broken off very shortly thereafter, and since then, we have been without further discussion.

I believe, and again I will try to say this as neutrally as I can, that the President is on record very clearly in expressing his willingness to reopen these discussions and to resume them pretty much where previous discussions ended under any of a number of possible arrangements or conditions. We in the executive branch certainly continue to do the work that would be necessary to prepare for such discussions. However, obviously, this is not a decision which I am in a position to make. I am hopeful that the process can get started again because I think there is still very much an opportunity to come to some agreement.

Mr. MILLER. Good. I'm glad to hear that. I think that's kind of my sense too. I wasn't sitting in the room in the White House either, but they are very close.

Mr. VLADECK. I wouldn't underestimate the importance of some of the philosophical differences. Again, I think that's why we have suggested over the last several months that some of the policy issues regarding the structure of choice, the extent of private insurance participation, and medical savings accounts be put aside and reach agreement on proposals which actually save money. Under this approach, I would think we could probably come to an agreement relatively quickly.

BALANCED BUDGET ACT VS BUDGET COMMITTEE

Mr. MILLER. Part of the problem now is the political scare tactics used by some outside organizations. It just makes it very difficult to talk seriously about the issue. I don't know if you have seen the ads or not, but they are rather pathetic. I think it is really sad that they're using such scare tactics. As you are aware, we really weren't that far apart. But to say that we want to destroy Medicare is just crazy.

Mr. VLADECK. Mr. Miller, if I may for the record, I would note that the current position of the Budget Committee leadership in both Houses has developed quite a distance from the position that was incorporated in the Balanced Budget Act, about \$100 billion if I'm not mistaken. I think that is not irrelevant to some of the political dialogue.

Mr. MILLER. Some of that's changing at the baseline, too.

Mr. VLADECK. Well, yes.

HOME HEALTH LEGISLATION

Mr. MILLER. Let me ask another question. One of the proposals you have now is to shift from Part A Home Health to Part B.

Mr. VLADECK. To shift a part of it, that part of it that was originally contemplated to be a Part B benefit, the non-post-acute home care expenditures.

Mr. MILLER. It costs about \$60 billion over seven years?

Mr. VLADECK. That's correct.

Mr. MILLER. That's the type of thing that people start to say we're playing smoke and mirrors up here.

Mr. VLADECK. I have personally had a lot to do with this proposal, and there were a lot of these types of suggestions floating around from both sides of the aisle last year. There really is a very significant policy issue here. If I could just take a minute to identify it, because it is very important to us in policy terms. In fact, we would like to move ahead with the policy apart from the accounting issues.

HOME HEALTH BENEFIT

When the Medicare home health benefit was first enacted in the initial legislation, it was very explicitly conceived as a post-acute benefit that would be provided as a way of facilitating patients discharge from the hospital. They were required to have had a prior hospitalization and that was in a sense the continuation of the acute episode for which the patient had been hospitalized. This is really the way in which the benefit operated in the Medicare program for the first 15 years or so.

In 1980, the Congress changed the law to eliminate the prior hospitalization requirement for the Part A benefit. At that time, the amount of Part B home health care, which did not require prior hospitalization and was never that substantial, basically disappeared. Virtually all of the home care utilization started occurring under Part A. Under the 1980 law, home care expenditures and utilization grew so rapidly that the then Reagan Administration in 1982 and 1983 took a number of administrative steps to scale back the benefit and to limit its application. That produced significant litigation which culminated in 1987 in a consent decree in which we were obligated to take several administrative actions which have significantly contributed to the compound annual rate of growth in the program.

If you look at the growth, most of it has been on the long-term care side. That is to say, the average number of beneficiaries receiving service has about doubled in the last six years, but the average number of visits per beneficiary who receives services has increased even more rapidly. We are now providing a long-term care benefit for many of the folks receiving Medicare home health care. It ought to be defined as such, and it ought to be a separate benefit. It ought to not require prior hospitalization but be more limited in scope, require more intensive medical review, and be less professionally intensive. We ought to get a handle back on that initial post-acute benefit. They've *de facto* become two separate benefits. If we can make that *de jure* by clarifying what is a Part A home health care visit and what's a Part B home health care visit, we think we can programmatically run both benefits better. We also believe that over time, whether it's Part A money or Part B money, we can save a considerable amount of money.

Mr. WICKER. We are obviously operating under the six-minute rule today rather than the five-minute rule. Mr. Bonilla, do you have questions?

Mr. BONILLA. Thank you, Chairman. Good morning, Mr. Vladeck.
Mr. VLADECK. Good morning, sir.

MEDICARE SUBVENTION DEMONSTRATION

Mr. BONILLA. Back in September of last year, you stated in a HCFA newsletter that HCFA should communicate and not dictate, educate rather than inundate, and innovate more than regulate. I would like to talk this morning a little bit about the latter, which that is the innovative part. Two of us on this subcommittee have the unique distinction of serving on both this subcommittee and the National Security Appropriations Subcommittee, that's Chairman Young and myself. I want to focus on the relationship this morning between HCFA and the Pentagon, and I'm sure you've heard a lot about this in the last year or so.

I understand you have been having discussions with the Department of Defense about a Medicare subvention demonstration project under which HCFA would reimburse DOD for health care provided to certain Medicare retirees. Could you tell me please where these discussions stand today?

Mr. VLADECK. Yes, sir. We actually had a meeting between ourselves and Defense Department staff including both the national security and health sides of the Office of Management and Budget last week, to take stock of where we were and talk about the future plans. We expect within four to six months to have the details of a demonstration project to test such a subvention arrangement all agreed upon and ready to go, at which point, providing there's legislative authorization at that point, we would hope that before the end of this year we could actually begin testing that idea.

Mr. BONILLA. Is this then a demonstration project that's supported by the administration?

Mr. VLADECK. Well, it is a demonstration project supported by the administration in principle. We need to do more work on the details for a very simple reason, sir, which is that the initial legislative proposals that would have encouraged this demonstration were scored by CBO as costing a significant amount of incremental dollars. As you are especially well aware, funds are not in excess supply on either the Medicare side or the national security side at the moment. We want to be able to design a demonstration that we can have some high degree of confidence of being budget neutral, both from the Defense Department's point of view and from Medicare's point of view. In order to do that, we have a lot more groundwork to do in laying the plans for this demonstration. That's what that four-to-six-month timetable contemplates.

Mr. BONILLA. Could you tell me, Mr. Vladeck, what costs that Medicare avoids each year when your beneficiaries receive health care in a military hospital, and have those avoided costs been increasing or decreasing?

MEDICARE SUBVENTION DEMONSTRATION

Mr. VLADECK. Sir, those are exactly the kind of numbers we are trying to identify. All sorts of suggestions as to what the numbers might be are thrown around. But neither the Defense Department nor we can make a very accurate estimate as to that number at the moment. We need to know what we're spending now in order to know what the incremental costs associated with a subvention arrangement might be. We got a set of datatapes from the Depart-

ment of Defense earlier this month and we are talking to them about selecting a contractor to do the analysis. Again, within that four-to-six-month time frame, we should be able to answer that question with a fair degree of reliability.

Mr. BONILLA. I also understand that DOD has agreed to continue to maintain the level of services it now provides to those who are eligible for both Medicare and care within the military hospitals so that Medicare will permanently rely on the Defense budget for a portion of its patient care. Is this correct?

Mr. VLADECK. The word "permanently" is more I believe than the Defense Department has agreed to. They have certainly agreed that during the life of the demonstration they would maintain their level of effort in support of those services in their system. I don't believe they've committed themselves to maintaining that level of expenditures after the conclusion of the demonstration. But that has been part of the discussions, yes, sir.

Mr. BONILLA. Could you tell us precisely what HCFA needs to do before the subvention demonstration project can begin? I know you've been talking about what's going on in the next few months, but have you identified any major challenges or major costs that we may not have anticipated?

Mr. VLADECK. Well, again, the categories of costs and of potential savings have been identified from the outset. Basically, we have folks who are now receiving services in Military Treatment Facilities. To the extent that they are receiving the services they need, the costs associated with those services are being borne by the Defense Department health budget. The questions are: what services are those folks likely to continue to receive; what services are they receiving that Medicare is already paying for in private sector facilities; what kind of shift in utilization would we expect; and what would be the net costs and savings? Those are the basic categories of discussion and it is just putting some numbers around each of those issues that's been the major focus of our discussions to date and the major focus of the efforts over the next few months.

Mr. BONILLA. If I have time remaining, I will move on to another subject. If not, I'll wait for the next round.

Mr. WICKER. You've got a couple minutes.

MEDICARE HANDBOOK

Mr. BONILLA. I would like to discuss something else. Back in July of last year, I remember saving a little clip where you were asked if you had thought about having to send a detailed description on multiple health care plans to each of Medicare's 37 million beneficiaries. You were quoted as saying, "I've been in Washington for two and a half years. I can imagine damn near anything." I don't know whether you made that reference to thinking that was a crazy idea or whether it was just a moment of exasperation. But on page eight of your testimony you now state that this budget allows HCFA to provide a Medicare handbook to all Medicare beneficiaries, ensuring that they have the most current information on all aspects of the program. So my question is, is this different from what you felt back then, or did I misread your original quote?

Mr. VLADECK. Well, let me say two things about that. First, we need, in addition to the Handbook, to provide beneficiaries in three-

quarters of the United States where they now have choices among multiple Medicare HMOs some better information comparing the plans. And we are experimenting with a variety of ways in which to provide that information, a variety of formats through which to provide that information, a variety of intermediary organizations that might help us get that information out. That is all market specific information that is critically important to making expanded choices in Medicare work effectively. That is also a very sizeable and ultimately an expensive undertaking for which we have not yet identified how we would provide the resources to do that.

However, I think that quotation was more specifically a reflection of my frustration about the Medicare Handbook. The Medicare Handbook is the basic description of Medicare benefits and how to get more information and more help. That is the Medicare program's analogy to the summary plan description that every private employer is obligated by law to provide every employee annually for ERISA-covered health or pension or other kinds of plans. We have published the Medicare Handbook since the program began. Only once during the last decade have we had an adequate budget to send an updated version to every beneficiary. We have been running a press run of about 2 million copies a year which we send to all new enrollees in the program and to other folks who request it. [CLERK'S NOTE: Subsequent to the hearing, HCFA revised this figure to \$4.3 million for the record.] In our customer surveys and our focus groups, beneficiaries and their caretakers suggest overwhelmingly it is the basic, single reference source to beneficiaries about their Medicare benefits and the average beneficiary's handbook is ten years old. [CLERK'S NOTE: Subsequent to the hearing, HCFA revised this time frame for the record to say "at a minimum six years old."]

We included money for a distribution to all beneficiaries on an annual basis in our FY 1995 budget, in our FY 1996 budget, and we have included it in the FY 1997 budget request. That money is not in the FY 1996 appropriation. We were able to use some end-of-year FY 1995 funding to pay for a handbook to be distributed in FY 1996. We have a specific request in the FY 1997 budget. It costs about \$20 million to print and mail 38 million copies of a 24-page document even at Government Printing Office prices. [CLERK'S NOTE: Subsequent to the hearing, HCFA revised this to say "32 page document" for the record.] We think it ought to be something that every beneficiary ought to be able to expect every year. But only once in the last decade have we had identifiable funds in our appropriations adequate to fund distribution of the handbook to all beneficiaries. And it is a source of continuing concern for us.

Mr. BONILLA. Mr. Vladeck, thank you. I may have an additional couple of questions that I may submit for the record.

Mr. VLADECK. I would be happy to respond to them, sir.

Mr. WICKER. Ms. Pelosi?

Ms. PELOSI. Thank you, Mr. Chairman. Dr. Vladeck, I'm aware that my colleagues have called to your attention their concern, and I will mine, and one that I know we share about the Hospital Trust Fund. I understand that you have addressed that concern this morning and I'll look forward to seeing your response on the record. I have been briefed somewhat on it. Forgive me for not

being here but I was meeting with some representatives of the Academy of Pediatrics for them to express their concern about changes in Medicaid and how it will affect children. I just say that as a comment. In response to my questions, if you want to bring it around to children, that would be fine, but I have some very specific other questions as well.

OPERATION RESTORE TRUST

Certainly, we're all concerned about waste, fraud, and abuse in the medical system. Can you tell us more, Dr. Vladeck, about Operation Restore Trust and justify your 1997 budget request for this activity. What more can be done to achieve cost-savings in this area?

MR. VLADECK. I would be happy to. Operation Restore Trust has its official first anniversary two weeks from Monday and we just began planning some appropriate celebration. But in effect, Operation Restore Trust was an activity we undertook without a separate appropriation, in part because of our frustrations that the congressional stalemate around health reform and related issues had left us without all the tools we needed to move as quickly as we wanted on the very serious problems of Medicare fraud and abuse. So what we did was go back to the drawing board to explore the extent to which we could appropriately use our demonstration authority to expand some of our program integrity activities and push ahead with some of the things we wanted to give high priority in the program integrity area.

The total funding of Operation Restore Trust is something on the order of \$8 million over two years, and we're just about at the halfway point. For that reason, we had to limit its targeting to five States—California, Texas, Florida, New York, and Illinois. It is targeted to particular subsets of the health care system where we had reason to believe we had particular problems, especially in the long-term care areas. The most important thing about Operation Restore Trust in its first year has been that even that relatively modest amount of money has been the vehicle to develop collaborative relationships among HCFA people, our contractors, the Office of the Inspector General, the Administration on Aging, all of whom are within the HHS orbit, State aging agencies, State ombudsman offices, but also with State Medicaid fraud control units and other arms of State Government and local groups in a way that is really unprecedented. Operation Restore Trust has led to a level of collaboration and joint efforts that have been remarkably productive and we think are quite replicable for other activities, both building in those States and moving on to other parts of the country.

I would like to give two quick examples. Through Operation Restore Trust in the States of Texas and Louisiana as a pilot and now in the four other Operation Restore Trust States, we are training our surveyors—the nurses, nutritionists, and public health professionals who inspect health care providers—in some basic issues of program integrity and having them communicate with our contractors. As long as they are in the facility, if they identify an issue that may not be a quality-of-care issue specifically but may be a fraud-and-abuse issue which they know how to look for, they know

to whom to report the information. They've had some additional training and they can actually go in on the survey and target on particular cases or particular claims or particular issues that have been identified by the fraud-control people. In several States, Medicaid and Medicare are jointly running datatapes about payments for services provided to nursing home residents who identify the very substantial number of instances in which Medicare and Medicaid have both been paying for the same items of equipment or the same therapy services or so forth for nursing home residents.

So that kind of collaboration really begins to build on itself and take off. I think, as we get through the formal evaluative process here, we will have lots of very encouraging progress to report, which is why the President's fiscal year 1997 budget contains a legislative proposal to really build on this model and make it a standard part of Medicare financing throughout the country on a permanent basis.

Ms. PELOSI. No wonder you said your one year observation would be a celebration.

Mr. VLADECK. Yes. I think there's good news to report and we have a lot of work still to do.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Ms. PELOSI. Dr. Vladeck, as you know, the Disproportionate Share Hospital program is an important source of vital funding for public hospitals in California and in other parts of the country. What impact would the administration's Medicaid proposal have on these public hospitals in terms of DSH payment, and how would this compare to the Republican leadership approach?

Mr. VLADECK. The Republican proposal, to the best of my understanding, does not have specific provisions for DSH at all. It leaves DSH dollars by and large in the base for calculation of the State amounts and leaves the determination about DSH programs to the States. The President's FY 1997 budget proposal, which is a refinement over last December's proposal, actually proposes to replace the current DSH program with one that is much more specifically targeted to those hospitals and other providers that are indeed providing a disproportionate amount to inner-cities. The Urban Institute has done a study that suggests that of total DSH dollars in the system as of 1994 or so, approximately one-third of those dollars actually represented incremental funding for care of Medicaid or uninsured patients, another third of those dollars were essentially a recycling of support for high DSH hospitals, whether public or private, and another third represented in effect net revenue to the States that was not being applied to the provision of disproportionate share services.

The President's proposal has a targeting methodology which attempts to essentially ensure that through a transition period 100 percent of DSH dollars go, in fact, to support services in high-DSH hospitals and other community providers. The methodology then takes some savings from the elimination of the other DSH expenditures over that roughly four-year period.

Ms. PELOSI. I will be interested to learn more about how the administration's proposal will work. The Urban Institute figures are startling. That's very interesting. As you know, we have a major

problem in California which was not addressed in the budget agreement even though New Hampshire and Louisiana did get their problem attended to. Congratulations to them. But the problem was not addressed in many of our other States, including a State as large as California.

Mr. WICKER. Ms. Pelosi, your time has expired.

Ms. PELOSI. May Mr. Vladeck just comment on that?

Mr. WICKER. Yes. Briefly.

Mr. VLADECK. Let me just make clear, we've spent a lot of time in the California DSH program in recent months and it is, in fact, a program that is supplying significant net additional dollars to hospitals caring for low-income people.

Ms. PELOSI. Thank you, Dr. Vladeck. Thanks, Mr. Chairman.

Mr. WICKER. Mr. Riggs.

MEDICAL SAVINGS ACCOUNTS

Mr. RIGGS. Thank you, Mr. Chairman. I would like to ask you, has HCFA had the chance to actually analyze the impacts that medical savings accounts would have on the Medicare program if MSAs were offered to Medicare beneficiaries?

Mr. VLADECK. We have not conducted very extensive independent analyses of that. We are very much aware of the Congressional Budget Office analyses and those of the American Academy of Actuaries. Given that and the general workload, our actuaries have not made independent estimates of the impact of the MSAs but they have reviewed both the Academy of Actuaries' numbers and the CBO numbers with some care and are not uncomfortable with them I think is probably the fairest thing to say.

Mr. RIGGS. What conclusion did you come to from that review?

Mr. VLADECK. Again, the CBO, if I remember correctly, suggested that if 1 percent of Medicare beneficiaries were to elect medical savings accounts as provided for in the Balanced Budget Act, that would have a net cost increasing impact on the program of something on the order of \$2.5 billion over the seven-year budget window. Again, one can argue whether it should be \$3 billion or \$2 billion or whatever, but I would say that our evaluation is that seems to be a reasonable estimate based on what we know and what CBO did to arrive at those.

BALANCING THE FEDERAL BUDGET

Mr. RIGGS. In your opening remarks, you state that this budget request is in line with two basic objectives of the President's budget, and at the same time reflects restraint and improved efficiencies consistent with achieving a balanced Federal budget in seven years. Do you conceive of any situation where the Federal budget could be balanced in seven years without restraining the growth of Medicare and Medicaid?

Mr. VLADECK. I could conceive of hypothetical scenarios, but I think the administration very strongly agrees that part of any overall effort to balance the budget has got to include reductions in the rate of growth of Medicare and Medicaid.

Mr. RIGGS. Would you agree with the political advertisements that have been running, some paid for by the Democratic National Committee and others paid for by big labor, that characterize the

Republican plans as slashing and gutting Medicare but characterize the President's proposal, your proposal presumably, HCFA's proposal as Medicare savings?

Mr. VLADECK. Mr. Miller was kind enough to begin some of this discussion by trying to set a tone. I don't want to get into too much of a who-struck-John in this. We very strongly believe that to this day there is a very significant difference between the President's proposals and the most recent revisions we've seen, and the revisions are not very detailed. For instance, the Republican leadership's proposals in terms of their impact on beneficiaries' lack of detailed information. Some of the items that were included in the Balanced Budget Act, although other discussions have evolved such as the medical savings account, would create very significant danger for the long-term well being of the Medicare program.

Mr. RIGGS. But I read through your testimony, sir, and it looks almost like an endorsement of the principles contained in the Republican Medicare Preservation Act which the President vetoed. You talked about cracking down on waste, fraud, and abuse in the program, the steps you have taken to actually implement an anti-fraud program. You talk about promoting managed care and communicating consumer information on the different managed care options to Medicare beneficiaries, and so forth. I can't believe, reviewing your testimony, that this comes from the same administration which has characterized our proposals as being so devastating to the future of Medicare.

Mr. VLADECK. Again, I don't know if this is the appropriate forum, but I could identify perhaps ten particular Medicare provisions of the Balanced Budget Act, many of them quite important to the structure of that act, with which we have a serious disagreement or reservations. Now if the issue is if one of those ten provisions to be dropped, whether there would be agreement between the administration and the Republican leadership on the future policies towards Medicare, I think the answer is at that point they would probably be pretty close.

REPORTS OF TRUST FUND STATUS

Mr. RIGGS. I'm sure Mr. Miller probably also pursued this line of questioning with you as well, but I would like your assurance here this morning, sir, that there has been no deliberate foot-dragging by HCFA with respect to reporting in a timely fashion crucial information on the financial status of the Medicare Trust Funds to the Congress. There is some concern that the Administration has been withholding information and that it has not been reporting information to Congress in a timely fashion. There is I think a noticeable lack of hue and cry with respect to the figures that were recently reported for the first half of this year regarding the money that the Medicare Trust Fund lost, I guess somewhere in the neighborhood of \$4.7 billion.

Mr. VLADECK. Well, those figures, Mr. Riggs, are almost exactly what was projected in the President's budget released in January and, in fact, are very close, as CBO reported yesterday, to the estimates from the Mid-Session Review last Summer. We did not generate a hue and cry because, again, those numbers were consistent

with what has been projected both by the administration and the CBO since last fall.

Relative to the first part of your question, let me say that I've learned from a number of different experiences over the last three years that one of the attributes of being the Administrator of the Health Care Financing Administration is that one has a formal organizational responsibility for a group of extremely independent, professional actuaries who often give us and our colleagues in the executive branch, including the President, information that we would rather not hear, and who often give the Congress information that the executive branch would just as soon not hear. Those are highly-respected, highly-independent professionals, and I wish I could influence the timing of their release of information or the content of their information.

But we are very proud of the tradition of actuarial independence at HCFA, and the actuaries are very proud of it. I told the current incumbent in the position that his selection was as close as I would ever get to analogy of choosing a member of the Supreme Court, because once you pick a chief actuary of HCFA he exercises his independent professional judgment, regardless of what the Administrator thinks, or what the President thinks, or who the Administrator is. So we can no more retard or accelerate the timing of information released from the actuaries than we could get a sitting member of the Supreme Court to change his mind on a decision. They feel very strongly about that, and I have to emphasize that for the record.

NURSING HOME INSPECTION TEAMS

Mr. WICKER. Mr. Riggs' time has expired. Mr. Vladeck, I want to ask you about the HCFA survey certification and enforcement regulations for nursing homes. Last year I withheld offering an amendment in connection with the agency's agreement not to impose fines for the first 90 days. However, now that the regulation is in effect, there's some very troubling data which have received attention from both sides of the aisle in the House and in the Senate, 72 percent of the Nation's nursing homes have been deemed out of compliance under these regulations, civil monetary penalties are imposed 25 percent of the time.

I have a letter here to Secretary Shalala from Senator Baucus, a Democratic Senator from Montana, in which he expresses the concern of people in Montana that the process is inconsistent, inefficient, greatly subjective, and has deviated from its original intent, which was to improve resident outcomes and satisfaction. Senator Conrad, again a Democratic Senator from North Dakota, expresses the opinion of people in his State that the current enforcement process may make the best the enemy of the good by failing to distinguish between facilities that chronically provide poor care and those with occasional minor deficiencies that have no direct negative effects on residents.

I would point out to you two examples of what I believe is over-reaching. In Wisconsin, a facility was cited for not complying with a life safety code standard which said furnishings and decorations are not to be explosive or highly flammable. Specifically, a surveyor observed an unattended burning candle in the sanctuary of a facili-

ty's chapel. The surveyor blew out the candle after being told by the facility priest that the candle had significant religious meaning and had burned continuously 33 years. Further, the candle was housed in a pyrex glass holder and set on a noncombustible surface away from combustible material.

Another example. In New York, a facility was cited because it did not serve pork. In fact, it hadn't served pork in 125 years; it is a Jewish nursing home. But the surveyors insisted nonetheless that pork be put on the menu.

Now, in light of these incidents and in light of the concerns expressed from both sides of the aisle, will you agree to revisit the definition of "harm" within this regulation?

Mr. VLADECK. Mr. Wicker, if I may, and I was with you up there until about the last minute or so, I am personally familiar with that story about the citation for failure to serve pork in Jewish home and hospital in New York City. I was personally involved in it. It occurred prior to the effective date of the new regulations, under the old regulations. It was a serious abuse of authority by the State surveyors which we immediately put a stop to. But it occurred well prior to July 1, 1995 when the new regulations went into effect. I happen to know that because I am personally familiar with that episode.

Both of those instances you cited are among a list of eight extreme cases that have been circulated by members of the industry and many Members of the Congress. Those instances we have been able to verify tend to be of a veracity level comparable to that of the pork and the Jewish nursing home. We have repeatedly asked the industry for more information about those cases we can't automatically identify from our records so we can track them down and correct such errors as there might be. They have refused to do that.

I would also add that under the new regulations—

Mr. WICKER. I'm glad you were with me up until that point.

REGULATIONS DEFINING "HARM"

Mr. VLADEK. Under the new regulations, we have surveyed almost 15,000 [CLERK'S NOTE: Subsequent to the hearing, HCFA corrected this figure to "over 13,300" for the record.] nursing homes. The law requires a relatively extensive process and in the course of those there have been some egregious errors made by surveyors. There have been things cited that should not have been cited, and there are some systemic problems with the system. We are working very hard to correct them. We have been meeting with representatives of the industry as well as with the States on a regular basis, as recently as last Thursday. We are committed to revisiting the definition of "harm" in the regulations and we've said that on a number of occasions. We have suspended the imposition of civil monetary penalties for certain deficiencies and have continued to maintain that suspension.

Relative to some of the statistics, let me just point out that while facilities have been threatened with civil monetary penalties in approximately 24 [CLERK'S NOTE: Subsequent to the hearing, HCFA corrected this figure to "22" for the record.] percent of the surveys, because the law requires that facilities with deficiencies be notified of potential liabilities for punishment if they don't correct the viola-

tion, fewer than 1.5 [CLERK'S NOTE: Subsequent to the hearing, HCFA corrected this figure to "1.2 percent" for the record.] percent of facilities which have been inspected under the new system have, in fact, had fines imposed on them. So we are trying to wade our way through some of the misinformation that is surrounding this process to address the very significant and real concerns that many folks engaged in long-term care and many of the folks in the State agencies have. I can't tell you we have fixed everything. I can't tell you there are no problems in the system. But I can tell you that it is a different system now than it was when we started in July because of mid-course corrections we've been making. It will be a different system this coming July than it was last July. We will continue to work very closely with providers of service as well as consumers and State agencies and Members of the Congress to continue to improve the system and eliminate some of the very real problems that have occurred.

Mr. WICKER. Let me just say I appreciate your statement today that you are committed to revisiting the definition of "harm" under these regulations. Let me just simply ask you, how long do you think that process will take, and what will be the context of revisiting that definition?

Mr. VLADECK. We have an agreement to meet with some representatives of parts of the provider community I believe the week after next to begin to talk about a work plan for that process. But we have also discussed with some of the provider groups having a series of what I guess Members of Congress might call Town Meetings that we bureaucrats call Listening Sessions at various points around the country to try to get a better feel from people involved in this process firsthand rather than the inside-the-Beltway representatives about what their concerns are, what problems they identify, and to use the information we gather from that process as the starting point for this reexamination of the "harm" definition. But I'm not sure we have a process agreement. Both of these activities are underway, and I would expect to have a work plan for that effort sometime during the month of May.

BALANCED BUDGET IMPASSE

Mr. WICKER. Thank you, Mr. Vladeck. I was interested in your response to the question of Representative Riggs, and I will simply ask you if you will submit for the record the ten specific items in the Balanced Budget Act with which you take issue.

Mr. VLADECK. Are we limited to ten items? I think I said at least ten. [Laughter.]

Mr. WICKER. Start with your top ten.

Mr. VLADECK. Whichever the Chair prefers.

Mr. WICKER. If you would submit ten or so for the record, I would very much appreciate it.

Mr. VLADECK. We will do that.

[The information follows:]

TEN SIGNIFICANT PROBLEMS WITH THE MEDICARE PROVISIONS IN THE CONFERENCE AGREEMENT

- 1) Excessive Increases in Part B Premium** - The Conference Agreement would increase the Part B premium to 31.5 percent of Part B program costs. Increasing the Part B premium beyond 25 percent of program costs would impose a heavy financial burden on a vulnerable population, many of whom have limited incomes.

- 2) Unnecessary Income-Related Part B Premium** - The Conference Agreement would establish an income-related, Part B premium for individuals with adjusted gross incomes (AGIs) in excess of \$60,000 or couples with incomes in excess of \$90,000. Individuals with AGIs above \$110,000 and couples with AGIs above \$140,000 would pay 100 percent of program costs. While the Administration supported an income-related premium in the context of its Health Security Act (HSA) in which Medicare benefits would have been significantly expanded, the President's FY97 budget clearly illustrates that this proposal is unnecessary to balance the budget by 2002. Further, under the income-related premium proposed in HSA, the Administration did not completely phase-out the general revenue contribution to the Part B premium. Such a phase-out would encourage wealthy enrollees, who are generally healthier than average, to disenroll from the program, thereby increasing average costs for remaining enrollees.

- 3) Harmful Cost Shifting to Beneficiaries** - The Conference Agreement would expose enrollees of private health plans contracting with Medicare to financial liability that is not permitted under current law. Plan enrollees could face: extra-billing by physicians and hospitals; new premiums for Medicare's share of the benefit package (premiums are currently allowed only for the beneficiary's share of the package); and unlimited premiums for supplemental benefits. Under current law, beneficiaries cannot be worse off financially as a result of enrolling in a private plan option. This principle should not be abandoned as part of efforts to restructure the Medicare program.

- 4) No Financial Protections for Low Income Beneficiaries** - The Conference Agreement provides no guarantee to elderly and disabled Medicare beneficiaries whose Medicare cost-sharing is now paid for by Medicaid that this coverage would continue. These low-income Medicare beneficiaries could be forced to pay these expenses out-of-pocket if their State chose to reduce current benefit levels.

The Conference Agreement also provides no guarantee of Medicaid coverage. States would have a virtually free hand in determining who qualifies for benefits, including eligibility rules on such issues as how homes or other assets are counted. Therefore, elderly and disabled Medicare beneficiaries who are now also entitled to Medicaid benefits could lose them, leaving them and their families to pay for the medical and long-term care costs not covered by Medicare.

- 5) Negative Consequences of Failsafe Budget Mechanism** - The Conference Agreement includes a failsafe budget mechanism that, if triggered, would automatically reduce fee-for-service payment rates to meet annual Medicare spending limits. The failsafe mechanism would create uncertainty for providers, which may reduce beneficiary access to services or lead to cost shifting

to other payors. Further, the Medical Savings Account (MSA) and private fee-for-service plan options provided in the Conference Agreement could have the effect of leaving the sicker beneficiaries in traditional fee-for-service Medicare. The resulting risk segmentation would increase the probability that the budget caps would be breached, triggering the failsafe mechanism and leading to a cycle of lower payments for providers in traditional fee-for-service Medicare. The use of a failsafe is a poor substitute for making the policy choices necessary to achieve the desired level of spending.

6) Decreased Quality in MedicarePlus Plans and Nursing Homes - For most plans, the Conference Agreement would turn over to States both the determination of eligibility for a Medicare contract and monitoring of existing contracts. In regard to quality requirements: private fee-for-service plans would not have to meet any quality standards; all other plans could meet requirements for external quality through private accreditation; and the 50/50 enrollment composition rule would be repealed. While the Administration believes that States should play a greater role in the contracting and plan monitoring processes, federal oversight is still needed because enrollees are Medicare beneficiaries and because federal trust fund dollars, not State funds, are at stake. The Administration also believes that: all plans should meet quality requirements; external quality review should remain an independent verification that quality care is being provided; and the 50/50 commercial enrollment requirement should be retained, with additional Secretarial waiver discretion, until an adequate system for quality measurement is in place.

In addition, the Conference Agreement would dismantle the nursing home provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) which were intended to protect the elderly and disabled and passed with bi-partisan support. The Conference Agreement would eliminate major quality standards and protections for nursing home residents while diminishing the Secretary's authority to hold facilities accountable to remaining quality standards. Hard data show that OBRA 87 nursing home standards have improved quality of care. Since the nursing home law went into effect, the number of physically or chemically restrained residents has been reduced. In addition, quality standards are higher, cases of abuse and neglect are more isolated, and offending facilities are more often identified and problems corrected.

7) Increased Program Costs with Medical Savings Accounts/High Deductible Option - The Conference Agreement would permit Medicare beneficiaries to enroll in a high deductible/medical savings account (MSA) option. The Administration believes that MSAs should not be an option under Medicare because they would increase risk segmentation and program costs. CBO has estimated that MSAs would cost the Medicare program \$4.6 billion over 7 years. In addition, given the extra-billing policy described above, beneficiaries enrolled in the MSA option could face unlimited liability for amounts above the plan's payment level. (See also discussion above of interaction of MSAs with failsafe mechanism.)

8) Increased Risk Segmentation and Reduced Choice - The Conference Agreement would permit Medicare beneficiaries to enroll in private fee-for-service plans and in plans that limit enrollment to beneficiaries affiliated with a union, association, or Taft Hartley trust (limited enrollment plans). The Administration believes that these plans should not be an option under

Medicare because they would increase risk segmentation. Limited enrollment plans would only participate if they know that their affiliated group is healthier than average.

In addition, when faced with excessive provider cuts to traditional Medicare and the opportunity to extra-bill under private fee-for-service plans (described above), providers may abandon traditional Medicare forcing beneficiaries, as a practical matter, to follow their providers. Thus, beneficiary choice could be reduced rather than increased.

9) Medigap Reforms Omitted and Weaker Anti-Duplication Provisions - The Conference Agreement does not include any Medigap reforms to require Medigap plans to accept all beneficiaries who elect coverage during an annual open enrollment period or to community rate premiums. These reforms are necessary to ensure that beneficiaries have true choices. Without them, a beneficiary who enrolls in one of our new plan options but then wants to return to traditional Medicare may be unable to obtain desired Medigap coverage at an affordable premium. Further, the Conference Agreement substantially weakens or removes restrictions on the sale of insurance products that duplicate Medicare or that duplicate other health insurance policies. The Administration believes that: Medicare enrollees should have annual open access to the full array of both managed care and Medigap options; Medigap plans should charge all enrollees in an area the same premium just as managed care plans are required to do; and Medicare beneficiaries should receive comparative information on all of their options, including both managed care and Medigap.

10) Imposition of One-Year Enrollment Lock-In - Under the Conference Agreement, beneficiaries would be locked-in to a plan for a year. Significant changes in monthly disenrollment rates are closely followed by HCFA and serve as an important indicator of quality problems. Under one-year enrollment lock-in, this information would be available only once a year. The Administration believes that the current month-to-month disenrollment option should be maintained.

Mr. WICKER. I think we have time for one more question. Mr. Bonilla, do you have anything further?

Mr. BONILLA. No further questions. I may have some for the record.

Mr. VLADECK. If so, we'd be happy to respond.

Mr. WICKER. Mr. Miller.

HEALTH PLAN CHOICES

Mr. MILLER. Let me follow up somewhat on what Mr. Riggs was talking about on Medicare. In your response to me, your comment of the negotiations at the White House back in December or January that we really weren't that far apart. But then in response to Mr. Riggs, when you referred back to the Balanced Budget you say are far apart, and we're not very close at all. So I am confused because my impression was in the negotiations we really weren't that far apart. We had some differences on the medical savings account. We think MSA's empower individuals, while the administration believes that medical savings accounts give too much power to the individual to manage their own health care and that it instead should be controlled out of Washington. That's a philosophical difference. But we could set that aside, we could do that.

I know we advocated means testing Part B Medicare premiums which you opposed even though you favored it two years ago. You talk about Town Meetings, I had a series of town meetings during the Easter break. One of the questions that came up is, "if Medicare is going bankrupt, why have the Part B premiums gone from \$46.10 down to approximately" \$43. Well, unfortunately that is partisan politics. Of course, another way to get around it is by shifting all the Part A Home Health over to Part B and make the taxpayer pay for it. So that's smoke and mirrors and that's too bad added to the rhetoric coming out of the ads.

You are covered, by the way, under the same plan as I'm covered by.

Mr. VLADECK. Yes, sir.

Mr. MILLER. So you get to choose, right? Choice of plans.

Mr. VLADECK. Yes, sir.

Mr. MILLER. In fact, my wife and I just changed plans this year from bace to a Blue Cross plan. I like the idea of having a choice. Before I came here, I didn't have a choice. There was only one plan available at the small company. But now it is kind of nice to have that choice; if you don't like the plan, move on to another plan. That's what we're talking about doing. I guess with all the HMOs, we don't have any in my area, it is basically the Government-run plan or none. But choice is a good idea, isn't it?

Mr. VLADECK. We believe that, as is the case with the Federal employees plan, choice is a good item. Choice requires, at a minimum, three things in order to serve beneficiaries, the first of which is a mechanism for financing consumer information and consumer education provided by neutral third party. The second refers to changes in the law affecting so-called "Medigap" policies, so that beneficiaries who choose to enroll in managed care plans but then change their mind, choose to disenroll, and return to fee-for-service with Medigap are able to purchase Medigap coverage even if they have a preexisting condition. This choice also requires that all

plans participating in the program operate under the same set of rules. None of these are characteristics of the Medicare provisions in the Balanced Budget Act.

So we feel very strongly about the right kind of choice and a level-playing field, and we do not believe that this was provided in the specific legislation passed by the Congress last year. In addition, participants in the budget discussions which took place over the winter, talked about some of the differences in a high degree of specificity. It seemed to me that there was an opportunity at least to come to some agreement on the very significant areas in which we disagreed, but then the process stopped.

Mr. MILLER. You talked about three areas, yet I thought we addressed those.

DIFFERENCES IN BALANCED BUDGET PLAN

Mr. VLADECK. There is no reference to Medigap reform in the Balanced Budget Act. There is a mechanism for information dissemination to beneficiaries but no means of financing it in the Balanced Budget Act. Capitated plans under the Balanced Budget Act operate under at least three and perhaps four sets of regulatory structures.

Mr. MILLER. Whatever plan offered has to have at least the same benefits as current Medicare.

Mr. VLADECK. That's correct, both plans provide that, but there are four sets of regulatory structures applied differentially to different kinds of plans in the Balanced Budget Act.

Mr. WICKER. Thank you very much, Mr. Vladeck. Your testimony will be very useful.

Mr. VLADECK. Thank you. We will get that additional material to you.

[Whereupon, the subcommittee considered other matters.]

[The following questions were submitted to be answered for the record:]

PAYMENTS TO THE HEALTH CARE TRUST FUNDS

Mr. Porter: Your budget proposes \$60.1 billion for the Payments to the Health Care Trust Funds account. This account jumped from \$37.5 to \$61.9 billion from 1995 to 1996, at least in part to repay a shortfall from the previous year. But the 1996 level seems to be sustained in 1997. Should we expect this to be the typical program level from here on out, and is this related to the setting of the Part B premium at 25 percent of program costs?

Mr. Vladeck: Since just about all of the Payments to the Health Care Trust Funds is for matching the Part B premiums, I will focus my answer in this area. As projected in the FY 1997 President's budget, payments for matching the Part B premiums are anticipated to increase by approximately \$5 billion in FY 1998, \$7 billion in FY 1999, and \$8.5 billion in FY 2000.

The payment amount is dependent on both the actuarial rates and premium rate established for the year. For some years, the trust fund assets have been more than sufficient to provide an adequate contingency reserve. As a result, the actuarial rates contained negative margins of contingency to draw down some of the assets of the trust fund and, therefore, smaller payments to the fund were necessary. FY 1994 was a case in point. Payments for that year actually declined by \$5.9 billion from FY 1993 due almost entirely to the planned draw-down of the trust fund assets. On the other hand, in other years, the assets have been insufficient to provide an adequate contingency reserve.

As a result, the actuarial rates contained positive margins of contingency, and larger payments to the fund were necessary. Currently, the Part B trust fund is projected to have sufficient assets to maintain an adequate contingency reserve. The projected actuarial rates in the President's budget contain margins of contingency to maintain the relative level of the contingency reserve. At this time, we do not anticipate that future actuarial rates will need large positive or negative margins that would distort the annual requirements for the payments to the trust fund.

The premium rate is the other variable that determines the payment amount. Obviously, the larger the premium rate, the smaller the payment amount. Under present law, the increase in the payments to the fund accelerates after 1998 due to the fact that the premium rate goes from covering 25 percent of program costs for the aged to a cost-of-living increase. For 1995, the \$46.10 legislated premium turned out to cover 31.5 percent of program costs for the aged after the actuarial rates were set.

IMPLEMENTATION OF THE MEDICARE TRANSACTION SYSTEM

Mr. Porter: Dr. Vladeck, could you bring us up to date on the implementation of the Medicare Transaction System [MTS]? What is its projected stream of costs from 1997 through its implementation?

Mr. Vladeck: Recently, HCFA has reached two milestones in the MTS project. First, last February, HCFA selected the system architecture for MTS which is based on a modern, client-server approach. The MTS will be flexible and expandable to facilitate the adaptation of new technology and payment methodologies. Secondly, we released the Request for Proposal for the MTS operating sites. Responses are due back to HCFA on July 22, 1996. Based on evaluation of these offers, we expect to award three contracts in the spring of 1997--two processing center contracts and one contract for a data analysis and operations center.

With regard to the cost stream for the MTS, the President's budget for FY 1997 contains an estimate for MTS of \$75 million. The bulk of these costs will cover operating site start-up and the transition of existing Medicare contractors to the MTS. We are currently developing a detailed transition plan which will map the movement of claims workload and data files from current standard systems and contractors to the MTS operating sites. Concurrently, we are refining our budget estimation methodology to account for the impact of workload transitions, as well as termination costs incurred by outgoing Medicare contractors. We expect to integrate a multi-year MTS cost estimate in the FY 1998 President's budget.

Mr. Porter: Compared to your current 77 Medicare contractors, how many operating sites do you expect to have under MTS?

Mr. Vladeck: The MTS is an integrated information technology system supporting Medicare administration and claims processing. There will be three operating sites initially. Two operating sites are processing centers where eligibility and claims processing is done and support data maintained. The third operating site is the data operations and analysis center (DOAC). The DOAC is the repository of summarized data, including eligibility information, claims and encounter data and other support documents.

MEDICARE CLAIMS PROCESSING

Mr. Porter: Explain why your budget requests a decrease in funding for Medicare claims processing, even though you are projecting a 3.5 percent increase in claims volume.

Mr. Vladeck: To prepare for the transition to MTS in the lean budget years ahead, HCFA recognizes the need to encourage efficiencies in contractor operations. To this end, HCFA will aggressively pursue reductions in the costs of claims processing operations. We expect that increased processing efficiencies will offset the cost of incremental claims workload.

Mr. Porter: Do you expect further gains in the share of claims that are submitted electronically, or have you already maximized the savings in that area?

Mr. Vladeck: We are currently receiving 80 percent of all claims in electronic form--99 percent from hospitals and laboratories alone. This industry-leading success obviously limits the extent of further growth, but we continue to be optimistic. We are hopeful that increasing electronic standardization in other areas, such as eligibility inquiries, claims corrections, and claims status lookup, will entice paper billers to move to electronic transmissions. Our electronic billing promotions will continue in full force, especially as we prepare for MTS.

SAVINGS THROUGH PAYMENT SAFEGUARD ACTIVITIES

Mr. Porter: How do you measure the savings achieved through payment safeguard activities? When payment safeguard activities are increased, do you review Medicare outlays to see if they are lower than the projected baseline as a result?

Mr. Vladeck: With the exception of the program integrity (fraud and abuse) area, contractors track all savings for each safeguard activity. The savings for Medicare Secondary Payer and Medical Review are reported monthly by each contractor. Audit savings are reported when an audit is completed. The program integrity area does not track savings.

Presently, we do not review the effect of safeguard activities on projected benefit outlays. The tracking of payment safeguards

savings relative to administrative costs for the various programs is used to develop a rate of return on investment which is an indicator of program effectiveness.

VARIATION IN CONTRACTOR PAYMENT POLICIES

Mr. Porter: The Committee has become aware of several circumstances this year that highlight the variation in contractor payment policies across regions, both in terms of the services covered and the price paid for services (even after adjusting for regional market prices). What are you doing to create greater standardization in Medicare reimbursement across regions?

Mr. Vladeck: HCFA has developed a plan to standardize pricing by migrating pricing functions from the contractors and standard systems maintainers into MTS. Pricing of items and services paid for under reasonable charge and pricing of drugs will no longer be done by local contractors. The result will be national standardization of pricing for these items and services. For example, under MTS, the MTS contractor will maintain all local history and charge data. HCFA's Bureau of Data Management and Strategy (BDMS) will use the data to perform the annual reasonable charge update and transmit the data to the MTS contractor to be installed in the system for claims processing. The result will be a single standardized method for calculating reasonable charge and eliminate the inconsistencies inherent in the current system.

In addition, HCFA has a number of continuing and special initiatives that promote standardization of reimbursement including the following:

In late 1995 HCFA directed all Medicare carriers to implement the Correct Coding Initiative (CCI) by January 1996. The CCI is a series of some 84,000 edits designed to ensure that the services and procedures billed to Medicare are accurately and consistently described and properly billed across the Nation.

HCFA has required the DME regional carriers (DMERCs) to develop standard regional medical review policies (RMRPs) that are consistent with national policy. By the end of the summer of 1996, the DMERCs will have developed and implemented a complete set of uniform RMRPs which will be monitored for effectiveness and added to as necessary to deal with unforeseen abusive situations.

HCFA has funded the multi-year development of the Medical Policy Retrieval System (MPRS) that will serve as a clearinghouse and database of the all current model and local medical review policies. The MPRS is designed to allow Medicare contractors to view, create, and customize local medical review policy.

COMMERCIAL, OFF-THE-SHELF SOFTWARE

Mr. Porter: Our Senate counterparts have urged your agency to use commercially available, private sector software packages to reduce wasteful Medicare billings. I know your agency disagrees with GAO estimates of the savings possible from this commercial software. Can you tell us why you don't think this would be a good intermediate step pending the implementation of MTS?

Mr. Vladeck. Medicare's transition to the MTS is close at hand. Modifying current processing systems to use these software applications would be expensive, and we believe strongly that it would not be a good business decision to undertake that cost and effort this close to the transition. Currently, there are 6 different Part B standard processing systems. The GAO estimates that it would cost Medicare \$10 - \$20 million to implement commercially available, off-the-shelf software into those 6 Part B standard systems.

Our research indicates that these commercially-available software applications contain edits to enforce medical policies that are in conflict with Medicare's own policies. Therefore, if HCFA chose to use them, some customization of the software applications would be necessary in order for Medicare's carriers to employ them within their automated claims processing systems. Moreover, HCFA would need to evaluate all current medical policies to ensure compatibility with the software. In some instances, we would have to modify, adapt, or create policies that are consistent with the editing done by these software applications. Until these activities were complete and the results reflected in the editing done by the software, Medicare would not realize savings anywhere near those reported by GAO. Consequently a return on investment will most likely not occur prior to our transition to the MTS.

The MTS is specifically designed to use commercially-available software products much like those evaluated by GAO. We plan to incorporate, wherever possible, commercially-available products within the MTS. To that end, on March 22, 1996 HCFA published in the *Commerce Business Daily* a Request for Information on commercially available, off-the-shelf software applications designed to edit medical claims for appropriateness.

SURVEY AND CERTIFICATION SHORTFALLS

Mr. Porter: There has been a great deal of Congressional concern this year about funding shortfalls in the Survey and Certification program. Is there presently a backlog in initial certifications, and, if so, is it concentrated in certain States?

Mr. Vladeck: The backlog of initial surveys is currently 1,570. It is our current policy to prioritize our workload so that we survey facilities that are currently participating in the Medicare program. Therefore, it is a possibility that initial surveys may not be done. Accordingly, the sole required criterion for prioritizing the State's initial survey workload is the access needs of the beneficiaries in the service area.

Currently, about 20 States are experiencing backlogs in conducting initial certification surveys of new providers. These States include: Virginia, Florida, Kentucky, South Carolina, Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Louisiana, Arkansas, Louisiana, Oklahoma, Texas, Kansas, Missouri, Colorado, California, and Arizona.

HOME HEALTH AGENCY INITIAL SURVEYS

Mr. Porter: With the funding provided in the omnibus spending bill last week and the related bill language changing the survey schedule for home health agencies and allowing deemed certification in certain instances, will you have enough resources to fund initial certifications?

Mr. Vladeck: The funding of \$1.8 million provided in the omnibus spending bill and the related bill language does not provide us with enough relief in FY 1996 to eliminate the severe backlog of pending initial surveys, which is currently 1,570.

We believe the number of requests by providers for initial surveys will continue to remain at its current pace. Therefore, we anticipate that our backlog will remain constant in FY 1996. Thus, the relief provided in the spending bill does provide some relief; however, it does not address the magnitude of our current funding shortfall.

Mr. Porter: Do you expect any backlog at the end of this fiscal year?

Mr. Vladeck: Although, we have received some relief as a result of the omnibus spending bill and the related language, we still anticipate a backlog of initial surveys at the end of FY 1996. This is due to the anticipated continued growth in providers seeking Medicare certification. However, we expect that all backlogs of initial certification surveys will be eliminated with the funding level requested in the FY 1997 budget.

LEGISLATIVE IMPACT ON SURVEY AND CERTIFICATION

Mr. Porter: Will the legislative provisions in the omnibus spending bill reduce your 1997 budget requirements for survey and certification?

Mr. Vladeck: The legislative provisions in the omnibus spending bill will not reduce our 1997 budget requirements for survey and certification. The savings that we experience from the legislative provision for a three-year HHA cycle, approximately \$8 million, will be used to ensure that all initial surveys are completed in a timely manner, along with significantly increasing our recertification coverage levels proposed in the President's budget from 25 percent to 40 percent for those for those facilities without a legislative 100 percent coverage mandate, i.e., other non-long-term facilities.

It is important that we have more oversight to recertify non-long-term care facilities. Currently, our recertification level is between 10 and 12 percent. This only permits recertification of a facility once every 8 to 10 years. To ensure the quality of care to our Medicare beneficiaries, on-site surveys should be conducted more frequently. However, at our current recertification levels, we are focussing our efforts on problem facilities. This is necessary to ensure the quality care our Medicare beneficiaries receive, as was previously noted.

In addition, it is critical that we increase funding for support contracts. Support contracts are needed in order to continue the development of quality indicators and the necessary data systems to refocus surveys systems and provide feedback on the quality of care provided to our beneficiaries. This additional contract funding is essential in order to provide training for the 6,000 surveyors nationwide, including funding for the satellite system, and to meet other evaluation and special survey requirements. The surveyor training is an ongoing process as a result of both high surveyor turnover rate and the implementation of improvements to the surveyor process.

Mr. Porter: Your 1997 budget assume 25 percent survey coverage for those facilities without a legislative 100 percent coverage mandate. What percent coverage of those facilities do you expect to achieve in 1996? Does that rate permit anything beyond responding to complaints?

Mr. Vladeck: In FY 1996, our level of coverage is between 10 percent to 12 percent for those facilities without a legislatively-mandated 100 percent coverage level. This only permits recertifying a facility once every 8 to 10 years. It is important that we have more oversight to recertifying non-long-term care facilities. To ensure the quality of care to our Medicare beneficiaries, on-site surveys should be conducted more frequently. However, at our current recertification levels we have decided to focus on problem facilities.

SURVEY VARIANCES

Mr. Porter: Your budget justification indicates that you have succeeded in reducing the variance between States in unit costs for surveys. What is the current variance?

Mr. Vladeck: The variance here is the difference in the level of resources used by the different State agencies to conduct seemingly similar surveys. There are a number of reasons why the costs would be different, e.g., salary levels, travel, size of facilities, size of agencies, etc. We have made considerable strides in the last 3 years in narrowing the States' national variance, thereby bringing in the outliers. We have continued our efforts to reduce the variance by examining support staff ratios, implementing national average survey times, and distributing State specific unit cost data for cost comparison.

INFORMATION COUNSELING AND ASSISTANCE GRANTS

Mr. Porter: Your 1997 budget chooses to fund the insurance counseling program and terminates rural transition grants. The omnibus spending bill took the opposite approach. Why do you feel that rural transition grants is the more meritorious program?

Mr. Vladeck: HCFA has chosen not to request funding for the rural transition grant program in FY 1997. While this program has helped some individual hospitals, it does not provide information to guide the development of future policies to improve access to and payment for rural health services.

With limited research dollars available, HCFA will encourage research and demonstration projects proposing to increase access to services in rural areas, as opposed to general, broad-based planning grants. Our research agenda will continue to look at access to health services in rural communities through projects such as: evaluation of the rural health clinic program; assessment of the use of telemedicine in rural areas; development of managed care options in rural areas within the Medicare Choices demonstration; impact of health care reform and section 1115 waivers on access for rural Medicaid beneficiaries; and the convening of a technical advisory panel of rural health experts to develop a rural health agenda.

The benefits of the Information Counseling and Assistance (ICA) grants are tremendous. The ICA grants program furnishes funds to States to support volunteer health insurance advisory programs. These programs offer information, counseling and assistance to Medicare beneficiaries relating to Medicare and Medicaid matters, as well as Medicare supplemental policies, managed care options, long-term care insurance, and other health insurance benefit information. States carry out the objectives of the grants by providing one-on-one insurance counseling, phone information and counseling through the use of toll-free lines, developing and distributing written informational materials, and holding group educational seminars and presentations. All 50 States, Washington, D.C., Puerto Rico and the Virgin Islands are participating in the program.

These counseling programs are an important component of HCFA's move to enhance customer service to Medicare beneficiaries. The ICA programs have a volunteer network that covers almost every city and county in the United States. These programs serve not only as an informational and counseling source to the beneficiary population on health insurance matters, but also work in partnership with HCFA and its contractors in disseminating consumer information on health-related matters and initiatives such as mammography and flu shots and participating in health fairs for this purpose. The ICA programs, through their extensive network, also serve as a link to the Medicare beneficiary population assisting and enabling HCFA to survey

and gather information as to the health insurance and other health needs of the beneficiary population.

BASIC RESEARCH BUDGET

Mr. Porter: Why do you feel it is important to increase your basic research budget by almost \$11 million, or 27 percent, in 1997, since it has not been funded at that high a level in at least the last five years?

Mr. Vladeck: While it appears that HCFA's basic research budget request for FY 1997 represents a substantial increase over previous years' appropriations, it actually is only \$4 million above our average appropriation and \$2.8 million less than FY 1994.

Beginning in FY 1995, the Medicare Current Beneficiary Survey (MCBS) was funded from HCFA's research budget for \$9.9 million. Prior to FY 1995, MCBS was funded from HCFA's administrative costs budget. The funding for MCBS at its current level is \$10 million per year. Our average budget for basic research--after deducting MCBS costs--is \$36 million. HCFA's basic research appropriations are as follows:

(\$ in millions)

	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Basic	\$35.6	\$36.0	\$43.3	\$35.2	\$30.0	\$40.5
MCBS				\$ 9.9	\$10.0	\$10.3
Total	\$35.6	\$36.0	\$43.3	\$45.1	\$40.0	\$50.8

Therefore, the portion of the \$50.8 million request that is for basic research in FY 1997 (\$40.5 million) is actually \$2.8 million less than FY 1994, when we received additional funds to conduct projects mentioned in House and Senate Appropriation Committee Reports, including telemedicine, and only \$4 million above our average appropriation. Thus, this request is only a modest increase over previous appropriations and will allow us to continue our commitment to telemedicine and to continue to conduct other critical research and demonstrations to improve and evaluate Medicare and Medicaid.

HCFA has many important initiatives planned for FY 1997, including research and demonstrations in the following project areas: (1) improvements in fee-for-service payment including projects to address volume, e.g., bundling physician/hospital payment, testing group volume performance; projects on prospective payment for home health, e.g., case-mix research and episode-based demonstrations; and research on renal payment methods; (2) improvements in managed care payment, including evaluation of demonstrations on alternative payment methods, e.g., competitive pricing, Medicare Choices, and risk adjustment; and (3) Medicaid initiatives, including the implementation and evaluation of the demonstrations to coordinate services for dual-eligible populations; and the evaluation of additional State demonstrations focusing on specific issues and populations such as mental health care costs, the disabled, etc.

ORGAN PROCUREMENT ORGANIZATIONS

Mr. Porter: HCFA is in the process of publishing a set of regulations governing the performance of organ procurement organizations. When do you expect them to be published?

Mr. Vladeck: HCFA issued an interim final regulation on September 8, 1994 that set forth conditions for coverage that must be met by OPOs. However, these regulations were issued after all of the 2-year designations for OPOs had taken place for 1994. Thus, the regulations did not impact the OPO designation process until that scheduled for 1996.

On May 2, 1996, we issued a final rule in the *Federal Register* that responded to the comments received on the interim rule, amended the September 8, 1994 standards somewhat, and provided for an exception process that would allow retention of OPOs that did not meet the standards under certain circumstances.

Mr. Porter: How many, if any, organ procurement organizations do you expect to go out of business with these new regulations?

Mr. Vladeck: We do not have sufficient information at this time to permit a prediction if any OPOs would go out of business. There are 13 OPOs that do not meet either the service area size standards or the performance standards or both.

The May 2, 1996 rules provide for an exception process that would allow retention of OPOs that do not meet the standards under certain circumstances. We have requested OPOs to advise us of their intention to seek an exception by May 13, 1996. It will be several months after that time before all of the exception requests can be adjudicated.

Based on the limited information we have available at this time, it appears likely that two of the OPOs which do not meet either the service area size or performance standards may not qualify for an exception. These OPOs will either go out of business entirely or reorganize into a new entity to compete for the same territory. Since one of the exception criteria is the absence of another high performing OPO willing to serve the area, we will not know if many of the other OPOs will qualify for an exception until we have had an opportunity to solicit offers from high-performing OPOs to service the areas.

Mr. Porter. Do you expect any decrease in organ donation to result from closing these organizations?

Mr. Vladeck. We do not expect a decrease in organ donation arising from the failure to redesignate an OPO that does not meet the performance or service area size standards. On the contrary, we note that there has been a significant increase in organ donation in 1995. We believe that a portion of this increase is directly related to the existence of rigorous performance standards on the OPOs.

If the performance or service area size standards do in fact result in the closure of any OPOs, the area serviced by these entities will not go unserved. Rather, the hospitals in the area will be serviced by an organization that has demonstrated its ability to procure organs at a significantly higher rate than the current organization. We believe that the replacement of low-performing OPOs with high-performing OPOs will result in an additional increase in organs available for transplant resulting in more saved lives and decreased waiting time for citizens in those areas.

Although OPOs that do not meet the standards have alleged that replacing them with another OPO would result in decrease in organs in the area, these organizations have not been able to present us with any empirical data demonstrating the merits of their allegation. Since the replacement OPO would in most cases be an established organization with demonstrated superior skills at organ procurement, we have no reason to believe that there would be even a temporary decrease in organ donation arising from the transition.

Mr. Porter: What is your response to industry representatives who feel that the new performance standards you are proposing do not measure performance of OPOs?

Mr. Vladeck: We are committed to reevaluating the performance standards as additional research becomes available. There is a myriad of factors that influence organ donation. For example, OPOs have argued that the standards which are population-based do not account for traffic fatality rates, cancer deaths, minority populations, infectious diseases, such as AIDS or age of population served. We will continue to evaluate these concerns.

At this time, when we look at the performance of OPOs, we find that many of the OPOs that serve difficult populations--populations that should make it difficult to achieve the performance standards--are actually the ones that perform best under HCFA's existing standard. For example, of the top ten performing OPOs, many serve disproportionately aged, minority or high-AIDS populations. Other OPOs have low traffic fatality rates but continue to excel at organ donation.

At this time we are not aware of any modeling activity that would allow us to quantify the impact of those factors that would intuitively seem to make organ donation more difficult for certain areas.

We believe that the OPO industry is aware, far better than we are, of the idiosyncracies of specific geographic areas. We believe that another OPO is not willing to risk losing its designation by moving into a territory that has unique characteristics that would make it impossible to meet the performance standards. In addition, we have provided an exception to retain those OPOs that serve areas in which another OPO is not willing to serve.

ORGAN PROCUREMENT ORGANIZATIONS

Mr. Porter: Would you consider postponing these new regulations until a study, currently underway, to determine organ donor potential in hospitals across the Nation is completed?

Mr. Vladeck: We are very interested in the results of the study on organ donor potential that is currently underway. However, we do not believe it is necessary to postpone the current standards until the study has been completed. As was previously mentioned, we believe that the reality of having rigorous standards in place has had a positive impact upon organ donation nationally. Most OPOs have responded to the standards by increasing the number of organs procured and transplanted. Many OPOs that did not make every effort to retrieve organs previously are now going the extra step to make that organ available. We believe it would be a major disservice to the American public whose very lives are dependent on the procurement of life-saving organs to postpone implementation of these standards while awaiting the results of a study.

We believe the current standards, while not perfect, provide a wide margin to allow for difference among OPOs. The current standards are set at 75 percent of the mean. This allows all OPOs a significant range to take into account unique circumstances of an area.

ORGAN PROCUREMENT ORGANIZATIONS

Mr. Dickey: It is my understanding that HCFA has adopted regulations to close organ procurement organizations (OPOs) if they do not meet a specific set of standards. It is my concern that these standards may not effectively measure the efficiency of OPOS. Currently, the Association of Organ Procurement Organizations is conducting a study to standardize the review of hospitals according to organ donor potential. Would it be possible to delay implementation of your regulation until the association has completed its study and can recommend suitable methodology for measuring OPO performance?

Mr. Vladeck: We are very interested in the results of the study on organ donor potential that is currently underway. However, we do not believe it is necessary to postpone the current standards until the study has been completed. As was previously mentioned, we believe that the reality of having rigorous standards in place has had a very positive impact upon organ donation nationally. Most OPOs have responded to the standards by increasing the number of organs procured and transplanted. Many OPOs that did not make every effort to retrieve organs previously are now going the extra step to make that organ available. We believe it would be a major disservice to the American public whose very lives are dependent on the procurement of life-saving organs to postpone implementation while awaiting the results of a study.

We believe the current standards, while not perfect, provide a wide margin to allow for difference among OPOs. The current standards are set at 75 percent of the mean. This allows all OPOs a significant range to take into account unique circumstances of an area.

SECTION 1915(b) WAIVERS

Mr. Stokes: As you know, much of the increase in managed care enrollment has resulted from the move to managed care Medicaid, and most of it was associated with managed care waivers. Can you give us an update on the status of the managed care waiver situation?

Mr. Vladeck: There are presently 25 section 1915(b) waivers, including initial proposals, modifications and renewals, in process. As of March 30, we had approved 91 section 1915(b) waivers for 41 States and the District of Columbia.

Mr. Stokes: Of those waiver demonstrations that are up and running, what have we learned from the Department's monitoring and evaluation of them?

Mr. Vladeck: Three 5-year evaluation contracts have been awarded to examine the impacts on: access to care; quality (including health status impacts, the process of care delivered, and satisfaction with care received); utilization of services; and costs, from Federal, State, provider, employer, and beneficiary perspectives. We will know more about these areas when the evaluations' first annual reports are completed. In the meantime, we are learning important lessons anecdotally from implemented States about such issues as contracting, enrollment and marketing. We are sharing this information with other States through technical assistance meetings.

MEDICAID RECIPIENTS IN MANAGED CARE PLANS

Mr. Stokes: What percentage of Medicaid recipients are now in managed care plans?

Mr. Vladeck: Approximately 11.6 million Medicaid recipients or 32 percent of these beneficiaries are now in managed care plans. This includes health maintenance organizations (HMOs), health insuring organizations (HIOs), prepaid health plans (PHPs) and primary care case management (PCCM) systems.

Mr. Stokes: Where are we with regard to ensuring that enrollment in these managed care plans translates into timely access to quality, and culturally-sensitive care?

Mr. Vladeck: The section 1915(b) waiver review process includes an analysis of how quality and access to services will be affected. States are asked to illustrate, as part of their waiver application, how both will be improved by the waiver.

States must ensure that a formal complaint and grievance process is available. We look at what measurable quality indicators the State plans to use to monitor the services received, and what arrangements have been made with external quality review organizations to evaluate the quality and delivery of services by HMOs, which is required by law. We also evaluate to what degree the State has encouraged or required, via contract or regulation, plans to implement Quality Assurance Reform Initiative (QARI) standards, and what plans the State has to implement Medicaid HEDIS or similar standards for data collection. HCFA requires that the State conduct focused clinical studies on (1) prenatal care and birth outcomes; (2) childhood immunizations; (3) pediatric asthma; and (4) one additional indicator applicable to the covered population.

The waivers must ensure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of individuals enrolled under the waiver. We ask what services are covered and excluded under the proposal and the rationale. We want to know how plans will coordinate or case manage

covered and non-covered services; what the current community standards are for travel time and distance from primary care providers; how plans will ensure access to Federally-qualified health center (FQHC) services; how plans will ensure access to transportation services for routine care visits; and, what services are available for disabled individuals.

The waivers should be tailored to be culturally appropriate for the population(s) covered. HCFA's marketing guidelines indicate that materials used for marketing, education and enrollment be produced in appropriate languages and reading levels. The means of reaching the beneficiary--either through brochures, radio and TV ads, newspapers, places of worship, community centers, etc.-- should be culturally appropriate. And, service personnel and clinicians who speak the appropriate languages should be available.

MEDICARE RECIPIENTS IN MANAGED CARE PLANS

Mr. Stokes: What percentage of Medicare recipients are now in managed care plans?

Mr. Vladeck: Approximately 4.2 million Medicare recipients or 11 percent are currently in managed care plans.

Mr. Stokes: Under Medicare, where are we with regard to ensuring that enrollment in these managed care plans translates into timely access to quality, and culturally-sensitive care?

Mr. Vladeck: Managed care plans are required to have an adequate network of providers for all of the health care services they have committed to provide through their evidence of coverage--minimally, the fee-for-service benefits. Primary care services and commonly-needed specialty services are to be available within 30 minutes' time, or whatever the practice is, for example, in a rural area. In addition, plans are expected to assess waiting times to receive appointments and to see the doctor on the day of the appointment.

Plans are also required to have an ongoing quality assessment and improvement program with activities to respond to complaints and areas identified for improvement. Many do surveys of members to highlight concerns and suggestions from their membership. HCFA monitors plans on an ongoing basis related to data which is submitted, as well as does site visits at least biennially.

HCFA is updating its standards in the broad area of quality assessment and improvement. We plan to specifically address cultural, socio-economic and age diversity related to service practice, policies, and administration. We would expect that if plans are not being responsive to their diverse membership, they would be receiving complaints which plans must respond to.

LEGISLATIVE PROPOSALS AND REFORMS

Mr. Stokes: According to the justification, the administration has included reforms in the budget request that would allow seniors choices among private health plans, and would make Medicare more efficient and responsive to beneficiary needs. What major legislative proposals, and reforms are reflected in the FY 1997 budget request? Under these proposals, what are the most significant benefits to patients served by Medicare and by Medicaid?

Mr. Vladeck: The major Medicare legislative proposals and reforms contained in the President's FY 1997 budget request include:

- Expanding the managed care options available to Medicare beneficiaries to include preferred provider organizations,

provider-sponsored organizations, and other alternative delivery systems that meet strong consumer protection standards.

- Extension of the life of the Medicare Hospital Insurance Trust Fund for at least a decade without imposing any new costs on Medicare beneficiaries.
- Ensuring that Medicare acts as a prudent purchaser and provides incentives to hospitals for efficiency by constraining updates for hospital operating costs, reimbursing reasonable levels for capital costs, reforming medical education payments, reforming add-on payments for extremely costly (i.e., outlier) cases, and reforming the rules governing transfers from a hospital to a post-acute care facility.
- Reforming Medicare financing for graduate medical education and training provided by the Nation's academic health centers and teaching hospitals by redirecting of medical education funds from managed care payments to teaching hospitals and establishment of a new commission on medical education and workforce priorities.
- Reforming payments for home health services and skilled nursing facility services by establishing interim payment systems in preparation for rapid implementation of new prospective payment systems for these services.
- Reforming the physician payment system by (1) tying allowable volume growth, which in turn affects fee increases, to the growth in real gross domestic product (GDP) per capita (plus an additional factor), and (2) implementing proposals that create incentives for physicians to deliver quality care efficiently.
- Establishment of a prospective payment system for hospital outpatient department services.
- Establishment of strong new protections against fraud and abuse in the health care system.

The most significant benefits to Medicare beneficiaries include:

- Maintaining the Part B premium at 25 percent of program costs as under current law.
- Investment of limited resources to expand cost-effective preventive benefits, including coverage for mammography, colorectal screening and preventive injections for pneumonia, influenza and hepatitis B.
- Establishment of a respite care benefit for families of Alzheimer's disease.

The major Medicaid legislative proposal and reform contained in the President's FY 1997 budget includes the following:

- Limits to Federal spending in Medicaid through a per capita spending limit and revisions to the Medicaid disproportionate share hospital program, combined with significant new flexibility provided to the States to administer the program.

The most significant benefits to Medicaid beneficiaries in the President's FY 1997 budget request for Medicaid include:

- Retaining the guarantee of coverage for all Medicaid beneficiaries to a meaningful benefit package.

- Retaining the Federal enforcement of the nursing home quality standards, as well as other quality of care provisions.

PATIENT OUTCOME PROVISIONS

Mr. Stokes: What proposed provisions are included to give needed attention to patient outcomes?

Mr. Vladeck: Beneficiaries enrolling in traditional Medicare or private plan options should receive high-quality care which increases the likelihood of needed and desired health outcomes. The President's FY 1997 budget request contains several provisions which would ensure that beneficiaries enrolled in private plan options receive high-quality care:

- As under current law, plans would be required to maintain quality assurance systems which stress health outcomes and the Secretary would certify that this requirement is met.
- Also, as under current law, plans would be required to both have an internal quality assurance program and be subject to external quality review. However, plans with private accreditation could be deemed to meet the internal quality assurance requirement.
- The current requirement for commercial enrollment at least equal to public program enrollment would be eliminated only after the Secretary, in consultation with the industry, develops a system for quality measurement.
- The current appeals process would be strengthened by adding a requirement for expedited appeals in cases where delayed treatment would place the health of the individual in jeopardy, risk serious impairment of bodily functions, or limit medically appropriate treatment options.

In addition to the provisions in the FY 1997 budget request, the Administration already has three quality assurance initiatives underway that stress health care quality outcome measures--(1) Medicare and Medicaid HEDIS, (2) the Foundation for Accountability (FACct) and (3) the Medicare Managed Care Quality Improvement Program (MMCQIP).

- The Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA) consists of performance measures that were designed for the employed population. HCFA was concerned because the HEDIS measures were primarily process-based rather than outcomes-oriented, and did not meet the special needs of Medicare and Medicaid beneficiaries.

As a result, HCFA participated in the development of Medicaid HEDIS, a joint effort of HCFA, NCQA, States, plans, and consumer organizations. Medicaid HEDIS was released to the States at the end of January 1996. Following that release, HCFA helped to fund training for the States in implementing Medicaid HEDIS.

HCFA also helped to fund a HEDIS workgroup to determine the types of Medicare program data that could be obtained through HEDIS. The subcommittee, chaired by a HCFA official, included representatives from plans, purchasers, and consumers, as well as HCFA staff. Workgroup recommendations included using HEDIS measures to help improve the health status of beneficiaries, assist plans in quality improvement activities, and inform beneficiaries about plan performance. The workgroup also suggested that additional outcomes measures be incorporated

into the HEDIS review protocol. HCFA anticipates that the next version of HEDIS (released for comment this summer) will include performance measures that impact the Medicare population.

- The Foundation for Accountability (FACct) was established in the summer of 1995 by large public and private-sector managed care purchasers. It includes significant consumer representation, as well as participants from governmental entities including HCFA, the Department of Defense, and the Office of Personnel Management. The FACct is designed to evaluate, endorse, and promote a common set of patient-oriented measures of health care quality focused on the outcomes of care including the populations receiving care through the Medicare, Medicaid, and Federal Employees Health Benefits Program.
- The Medicare Managed Care Quality Improvement Program (MMCQIP) was developed by HCFA in response to the view that peer review organization (PRO) review was punitive and did not contribute to substantial quality improvement. MMCQIP will encourage collaboration between the PRO and the managed care organization, with a focus on improving the quality of care in identified problem areas. Under MMCQIP, 23 risk HMOs and five PROs--Minnesota, Florida, New York, California, and Pennsylvania--voluntarily agreed to pilot test the new approach. The plans participating in the pilot agreed to work together to develop a protocol to improve the outcomes for patients with diabetes. Towards that end, a panel of experts developed a series of diabetes diagnostic measures--including podiatry, ophthalmology, and hematology examinations--in order to improve the care of Medicare managed care plan enrollees with diabetes.

In addition to pilot testing the series of diabetes diagnostic measures, several plans are working with PROs in Arizona, Oregon, Nevada, Washington, Alabama and Florida to develop their own quality improvement programs in other areas such as flu immunizations, mammography screening, and identifying depression. By October 1996, all plans will be required to work with the PROs in their respective States to develop individualized quality improvement programs.

COLLABORATIVE EFFORTS WITH AHCPR

Mr. Stokes: What major collaborative efforts are underway between HCFA and the Agency for Health Care Policy and Research?

Mr. Vladeck: HCFA's Office of Research and Demonstrations (ORD) and AHCPR staff meet regularly to exchange information about solicitations, funding plans and awards. Staff from both agencies review and comment on research grant and contract solicitations for each agency and place members on review panels convened by the other agency.

In addition, ORD and AHCPR staff work together on numerous joint projects. These include: a project designed to identify and measure the extent of physicians' responses to changes in Medicare fees brought about by the implementation of the Medicare fee schedule; a project using HCFA MDS+ data files to update the clinical practice guidelines in areas related to long-term care; a project that combines Medicare expenditure data and nursing home use and expenditure data from two national surveys to estimate lifetime acute and long-term care expenditures for the over 65 elderly by gender and age at death; and a study to provide a more precise estimate of lifetime medical and long-term expenditures for the elderly, as well as determining changes in medical care patterns in the last 2 years of life.

HCFA's Data Quality Steering Committee includes an AHCPR representative who is liaison with HCFA on identifying data quality problems as experienced by AHCPR researchers and their contractors.

HCFA has for several years now been providing continuous support for AHCPR by developing custom extractions of Medicare data for the Patient Outcomes Research Teams, Minority Centers and other research organizations sponsored by AHCPR.

Specific examples of ongoing support provided include:

- Providing analytical and programming services for AHCPR and other customers requesting Medicare and Medicaid data. These services provide custom datasets to users, information developed using datasets extracted from database repositories, continued maintenance and required enhancements to database access/extraction facilities and developmental activities to accommodate new initiatives or legislative mandates.
- Providing programming, medical coding, and analytical services for data quality initiatives; as well as providing statistical and econometric analysis services for data quality initiatives.

INITIAL MEDICARE CERTIFICATION SURVEYS

Mr. Stokes: I understand the agency has not been able to conduct initial Medicare certification surveys, and that there is virtually a freeze on such surveys. What is the extent of this problem in FY 1996 and the projection for FY 1997?

Mr. Vladeck: The backlog of initial surveys is currently 1,570. It is our current policy to prioritize our workload so that we survey facilities that are currently participating in the Medicare program. Therefore, in FY 1996, it is a possibility that initial surveys may not be done. Accordingly, the sole required criterion for prioritizing the State's initial survey workload is the access needs of the beneficiaries in the service area.

However, we expect that all backlogs of initial certification surveys will be eliminated with the funding level requested in the FY 1997 President's budget.

SOLVENCY OF MEDICARE

Mr. Stokes: For the record, in your professional judgment, what is your assessment of Medicare's solvency, what should be done to ensure the solvency, and also highlight how the Administration is addressing the solvency issue?

Mr. Vladeck: The solvency of the Hospital Insurance (HI) Trust Fund is a very critical issue, and one that we have been highlighting since this Administration began. The 1995 HI Trustees' Report projected that the HI Trust Fund would go bankrupt in 2002 under current law. The actual balance of the HI Trust Fund, however, has been depleting somewhat faster than the trustees predicted last year. Consequently, the upcoming 1996 HI Trustees' Report may project a depletion date that is earlier than last year's projection.

We have consistently emphasized the need to reduce and control Part A spending in order to extend the life of the HI Trust Fund. To this end, the Administration has proposed a Medicare savings package as part of the President's Balanced Budget Proposal and the President's FY 1997 Budget Proposal that would ensure the solvency of the HI Trust Fund for at least a decade. If enacted, this proposal would not only protect Medicare beneficiaries in the short term, but also give the President and Congress more time to address the longer-term trust fund solvency issues that will arise when the "baby-boom" generation becomes eligible for Medicare.

OHIO MEDICAID WAIVER

Mr. Stokes: For the record, please provide an update on the Ohio Medicaid waiver, including the State's action to date, revisions to the waiver, projected implementation by the State, the number of individuals who would be covered, changes in the terms and conditions, and the period of performance.

Mr. Vladeck: OhioCare was approved on January 17, 1995. The proposed implementation date is July 1, 1996 through June 30, 2001. The estimated enrollment is 1,458,626.

The originally-approved OhioCare demonstration had three main features: the implementation of statewide Medicaid managed care; development of managed care for special health related services (SHRS), which are delivered by individual State departments, such as the Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services; and the expansion of Medicaid eligibility to cover the uninsured population with incomes up to 100 percent of the Federal poverty level.

Ohio has received legislation to implement statewide mandatory managed care for current eligibles, but has not received the necessary legislation to expand coverage to the uninsured. Also, the State has been given the legislative authority to implement only certain aspects of the proposed managed care plan for SHRS.

On July 1, 1996, Ohio will implement mandatory managed care for current eligibles in those metropolitan areas of the State currently without mandatory programs. Ohio will also begin to develop voluntary managed care programs in the rural parts of the State, and eventually phase them into mandatory programs over time.

The State's plan to test the use of managed care for the provision of SHRS has been put on hold. Currently, a task force consisting of representatives from the Medicaid agency, the Governor's office, the legislature, and the counties is being established to develop an integrated managed care system for SHRS and, in particular, mental health and drug and alcohol services. These services will be brought under managed care in July 1997.

No specific changes have been made to the special terms and conditions. However, additional conditions, which were not added to the formal terms and conditions, were placed on Ohio as part of the approval of its yearly continuation application. HCFA authorized with conditions, the implementation of mandatory managed care in certain metropolitan areas of Ohio without the State implementing two components of its original proposal, the expansion of eligibility to the uninsured and the development of managed care for special health-related services. The conditions are: the State must work to ensure the participation of minority-owned and community-based managed care networks in the demonstration, and the successful implementation of the comprehensive quality assurance mechanisms proposed under this demonstration. HCFA will monitor the efforts of the State to meet this goal.

IMPACT OF MEDICAL SAVINGS ACCOUNTS

Mr. Hoyer: The House-passed version of the Kennedy-Kassebaum health insurance reform bill would take \$2.6 billion in Medicare anti-fraud savings and use it to promote medical savings accounts. I am concerned that this is an expensive experiment which will ultimately undermine the Medicare system. How much do we know about widespread use of MSAs among a population comparable to that served by Medicare? What would you expect the impact of MSAs on Medicare to be?

Mr. Vladeck: First, I would note that Kennedy-Kassenbaum does not contain Medicare MSAs. The House bill contains provisions only for MSAs for the under 65 population. Although there is some limited experience with MSAs offered to an employee population, there is no experience with this insurance coverage approach for a population over 65 years old. Currently, several States have enacted MSA-authorizing legislation, although these vary in terms of catastrophic limits, use of MSA funds, State tax treatment, etc. Some, mostly smaller employers, are offering an MSA option to their workforce, and they report positive cost containment results and high employee satisfaction. However, there is a lack of empirical cost or utilization data to verify these assertions.

The American Academy of Actuaries analyzed the impact of MSAs and stated that "despite our persistent requests, the Academy was unable to obtain information from Golden Rule, or other prototype MSAs, that would be essential for a thorough, quantitative analysis of these cases." Because the elderly population covered by Medicare has different health care needs, financial resources, and has different behavioral responses to health insurance coverage, e.g., it is a very risk-averse group--80 percent of Medicare beneficiaries are covered by a supplemental policy, it is impossible to accurately forecast how this population would react to, or participate in, a MSA program.

Any Medicare MSA plan would fundamentally change the social contract of the Medicare program by allowing the "cashing-out" of the entitlement. Under a Medicare MSA plan, there would be no Federal oversight of the provision of services or payment for those services. The budgetary impact on the Medicare trust funds may be significant, depending on the MSA program design. Our inability to accurately predict future expenses, either at a programmatic or individual level, together with our dearth of empirical data on how the elderly would react to a MSA plan, make this a very risky proposition. There have been a number of studies of the impact of a MSA option on the Medicare program. They have uniformly found that a MSA would cost the Medicare program substantial sums and further deplete the Medicare trust funds. For example, the Lewin/VHI report (September 25, 1995) estimated that a MSA option would increase Medicare program costs about \$15 to \$20 billion over the next seven years. This was based on the assumption that only about 3 percent to 5 percent of beneficiaries would enroll in an MSA. The report also predicted that healthier individuals would enroll, leaving the Medicare program in a more tenuous position, unable to spread the risk over a larger, diverse group of healthy individuals.

The Congressional Budget Office assumed that 1 percent of the eligible Medicare population would select the MSA option initially, and that this would grow to 2 percent by 2002. Based on these assumptions, this option would increase total program costs by about \$4 billion over 7 years.

Allowing Medicare beneficiaries to enroll in MSA could lead to a self-selection bias against traditional Medicare, with healthy individuals choosing the MSA and others remaining in the traditional Medicare program. An August 1995 report prepared for the Henry J. Kaiser Foundation found that even if adverse selection stopped short

of a death spiral, risk selection would still be a problem for less-healthy enrollees. The remainder of less-healthy elderly persons in the traditional program would cause the cost per case and the cost per enrollee to increase. These cost increases would necessitate some changes in the traditional program, either in the form of increased copayments or reduced benefits, that would leave the less-healthy enrollees worse off than they were before the MSA option was introduced.

1993 SOCIAL SECURITY TAX REPEAL

Mr. Hoyer: I was interested by Speaker Gingrich's Sunday morning talk show promise to repeal the 1993 increase in Social Security subject to tax. However, these funds are dedicated to the Medicare Part A trust fund, and repeal will drain an estimated \$36.6 billion out of Medicare in six years. Could you describe the impact on Medicare of implementing this proposal?

Mr. Vladeck: The President's 1993 five-year economic plan extended the life of the Medicare Part A trust fund by an estimated three years by constraining spending growth and increasing revenue to the Part A trust fund. One way in which the President's plan improved the solvency of the Part A trust fund was by increasing the percentage of Social Security benefits of well-off seniors subject to taxation, and dedicated that revenue to the Part A trust fund.

Repealing this provision would shorten the life of the Part A trust fund by several months.

ORGAN PROCUREMENT ORGANIZATIONS

Mr. Hoyer: I have received a number of letters from Maryland organ transplant centers and support networks regarding new HCFA standards regarding organ procurement organizations (OPOs). Could you explain for the Committee why the new standards are necessary, what type of standards have been developed, your relationship with the Association of Organ Procurement Organizations through the development of these standards, and where the standards are now in terms of comment period, possible revision, and implementation?

Mr. Vladeck: The Transplant Amendments Act of 1990 (P.L. 101-616) required the Secretary of Health and Human Services to publish regulations that implement the provision of the law requiring an OPO to have a defined service area that is of sufficient size to ensure maximum effectiveness in the procurement and equitable distribution of organs. The legislative history was specific and stated that proposed regulations were to be published by February 14, 1991.

Further, the legislative history indicated a view by the Congress that the standards are rigorous given that the previous standards enacted in the law required that OPOs to procure organs for 50 donors per year. We and the industry believed these standards to be too rigorous and asked Congress to amend the legislation to provide some flexibility, which it did in implementing P.L. 101-616.

In following the statute, we issued a proposed rule in June 1991. In developing this proposed rule, we worked closely with the Association of Organ Procurement Organizations (AOPO), which was the only OPO trade association at that time. The proposed rule set forth a large number of alternative standards for consideration by the industry. One of the performance standards, the one ultimately implemented by HCFA, was originally proposed by AOPO.

We received a small number (38) of comments on the proposed rule. The comments that we received from the industry overwhelming favored the standards adopted in the 1994 interim final rule. Likewise, we received only 33 comments on the interim final rule that was published in September 1994. Many of the comments related to

provisions other than the service area size and performance standards, such as composition of the board and HIV testing.

In summary, the interim final rule set forth both a service area size standard which provides that OPOs must meet one of four alternatives for minimum size. The four alternatives are the following: OPOs procure organs from 24 donors per year over a 2-year average; serves an entire State; if a new entity, has the potential to procure organs from 50 donors; and, if located in a noncontiguous State or U.S. territory, OPOs procure kidneys that are equal to 50 percent of the national average population's adjusted average.

The performance standards specified that the OPO must meet 75 percent of the national average for four of the five following standards: donors per million populations; kidneys procured per million populations; kidneys transplanted per million populations; extra-renal organs procured per million populations; and extra-renal organs that are transplanted per million populations. Additional performance standards, such as 24 donors per year and an average of three organs per donor have been deleted in the final rules issued May 2, 1996.

During the comment period on the interim rule, AOPO suggested that we consider basing the performance standards on death rates in an area. They also recommended an exception process for OPOs that do not meet the standards, and recommended no size criterion for OPOs. We met with AOPO several times during the development of the final rules to discuss their issues more fully.

In addition, since the publication of the proposed rule in 1991, another trade organization for OPOs was formed, called ACORD. We also met with this organization which represents a significant number of OPOs in developing the final rule.

We pointed out to AOPO that the law was clear that a minimum size criterion was required to be set by the Secretary. We acknowledged that an exception process was necessary in order to avoid the situation where an area may be left with no OPO willing to serve it due to its unique characteristics that make it difficult to serve. We discussed the difficulty of obtaining death data with AOPO, and pointed out the possible detrimental effects of that factor on certain large urban OPOs. We also met with ACORD to discuss these factors.

We issued a final rule on May 2, 1996 that provided for an exception process, among other actions. The final rule does permit comment but is restricted to certain issues not previously subject to comment. We stated in that rule that we are interested in further refining the performance standards in the future and will be considering any studies that may be done for its impact on performance standards.

JUSTIFICATION OF THE BUDGET ESTIMATES

HEALTH CARE FINANCING ADMINISTRATION

STRATEGIC PLAN BUDGET

Fiscal Year 1997



Volume Contents

BUDGET IN BRIEF

Funding Summary	1
Putting HCFA in Perspective	2
Budgetary Pressures	5
HCFA's Highest Priorities	6
Strategic Plan	7
Goals	8
Conclusion	13

MEDICAID GRANTS TO STATES

Appropriation Language	I-1
Language Analysis	I-2
Authorizing Legislation	I-4

BACKGROUND OF MEDICAID PROGRAM	I-4
--------------------------------------	-----

MEDICAID MANAGED CARE	I-5
-----------------------------	-----

SAFEGUARDING HEALTH CARE FOR THE MOST VULNERABLE RECIPIENTS, GROWING CASELOADS	I-10
---	------

SECTION 1115 STATEWIDE WAIVERS	I-14
--------------------------------------	------

Fostering Innovative Approaches to Medicaid	I-14
Expanded Coverage to Low-Income Uninsured	I-14
Developed Models for Monitoring Quality	I-15
Evaluated Programs	I-16

BENEFICIARY SERVICES	I-16
----------------------------	------

RATIONALE FOR BUDGET ESTIMATE	I-16
-------------------------------------	------

 HEALTH CARE FINANCING ADMINISTRATION

State Estimates for Medical Assistance Payments and State and Local Administration (SLA)	I-16
Medicaid State Survey and Certification	I-17
State Medicaid Fraud Control Units	I-17
Impact of Proposed Legislation	I-17
Per Capita Cap	I-18
Disproportionate Share Hospital (DSH) Payments	I-18
Transition Pools	I-18

PAYMENTS TO HEALTH CARE TRUST FUNDS

Appropriation Language	II-1
------------------------------	------

GENERAL STATEMENT	II-2
-------------------------	------

PROGRAM MANAGEMENT III-1

Appropriation Language	III-1
Language Analysis	III-2

GENERAL STATEMENT	III-4
-------------------------	-------

MEDICARE CONTRACTORS III-5

Authorizing Legislation	III-5
-------------------------------	-------

PRIORITIES FOR FY 1997 III-5

Medicare Benefit Integrity System	III-5
Medicare Transaction System	III-6
Control Medicare Expenditures	III-7
Improve Customer Service	III-7
Reduce Administrative Costs	III-7

Volume Contents

Support Managed Care	III-8
Improved Beneficiary and Provider Services	III-8
RATIONALE FOR THE BUDGET REQUEST	III-9
Payment Safeguards	III-11
Medicare Secondary Payer (MSP) Legislation	III-13
Productivity Investments	III-13
Medicare Transaction System	III-13
Contractor Transitions	III-14
Administrative Simplification	III-14
Improve Beneficiary and Provider Services	III-14
National Provider Identification	III-15
Claims Processing	III-16
Bill/Claim Payment	III-16
Reimbursement	III-17
Beneficiary and Provider Services	III-19
Appeals	III-19
Beneficiary Communications and Provider Education and Training	III-20
Participating Physician and Supplier Program	III-20
STATE SURVEY AND CERTIFICATION	III-21
BACKGROUND OF THE STATE SURVEY AND CERTIFICATION PROGRAM	III-21
Growth of Facilities	III-22
Health Care Quality Improvement Program	III-23
Enforcement	III-25
RATIONALE FOR THE BUDGET ESTIMATE	III-28

HEALTH CARE FINANCING ADMINISTRATION

Direct Survey Activities	III-28
Unit Cost Budget Methodology	III-30
SUPPORT CONTRACT ACTIVITIES	III-31
Review for Conditions at Psychiatric Hospitals	III-31
Psychiatric Hospital Surveys:	
Special Conditions	III-31
Redesign of the Survey Process	III-32
Maintenance and Enhancement of State's	
Clinical Databases	III-32
Redesign Survey Protocols	III-32
Minimum Data Set Centralized Database	III-32
Develop Test and Validate Quality Indicators (QIs)	
For Health Care Facilities	III-33
Training	III-33
Change to Surveyor Training Program	III-33
Satellite Training Network	III-33
Program Evaluation and Oversight	III-34
Investing in Improved Efficiency	III-34
Outcome and Assessment Information Set—	
Data Infrastructure and Support System	III-34
LABORATORY INSPECTIONS UNDER THE CLINICAL	
LABORATORY IMPROVEMENT AMENDMENTS OF 1988 ...	III-35
Authorizing Legislation	III-35
BACKGROUND OF THE CLIA PROGRAM	III-35
User Fees	III-37
Current Findings	III-37

Volume Contents

Methods of Correction	III-38
RATIONALE FOR THE STATE SURVEY	
BUDGET ESTIMATE	III-38
RESEARCH, DEMONSTRATIONS AND EVALUATION	III-41
Authorizing Legislation	III-41
BACKGROUND	III-41
Accomplishments	III-42
FY 1997 INITIATIVES	III-44
Monitoring and Evaluating Health System Performance	III-44
Improving Health Care Financing and Delivery Mechanisms	III-45
Meeting the Needs of Vulnerable Populations	III-46
Improving Consumer Choice and Health Status	III-46
ADMINISTRATIVE COSTS	III-49
Authorizing Legislation	III-49
Background	III-49
RATIONALE FOR THE BUDGET REQUEST	III-50
Medicare	III-50
Claims Payment	III-51
Beneficiary Services	III-52
Market Research	III-53
Provider and Beneficiary Outreach	III-53
Electronic Information Support	III-53
Quality Assurance	III-55
Program Integrity and Management	III-57

 HEALTH CARE FINANCING ADMINISTRATION

Medicaid	III-60
Program Payments to States	III-60
Beneficiary Services	III-61
Quality Assurance	III-62
Partnership with States	III-64

SUPPORTING TABLES

Appropriation Language	IV-37
Language Analysis	IV-38

GENERAL STATEMENT	IV-39
-------------------------	-------

SUPPORTING MATERIAL

Proposed Legislation Summary	IV-41
Significant Items	IV-42

*List of Volume Figures and Tables***List of Volume Figures and Tables****BUDGET IN BRIEF**

Figure 1	FY 1997 Program Management: Less than 1 Percent of HCFA Outlays	2
Figure 2	HCFA's Beneficiary-Support Network - 1997	4
Figure 3	72 Million Beneficiaries Served by HCFA	6
Table 1	FY 1997 Appropriations Request	14
Table 2	Summary of Significant Changes in Program Management Funding Levels	15

MEDICAID GRANTS TO STATES

Table I-1	Budget Authority by Activity	I-4
Figure I-1	Projected Medicaid Service Growth, FY 1996 - FY 1997	I-7
Table I-2	Projected Benefit Service Growth, FY 1996 - FY 1997	I-9
Figure I-2	The Contribution of Caseloads and Prices to the 7.8 Percent Average Annual Growth in Outlays between FY 1993 and FY 1997	I-10
Figure I-3	Projected FY 1997 Recipients and FY 1997 Outlays by Eligibility Category	I-11
Table I-3	Number of Recipients	I-12
Figure I-4	Medicaid Recipient Growth Rates from FY 1996 -FY 1997	I-13
Table I-4	Medicaid Coverage for the Uninsured Under Section 1115 Waivers	I-15

HEALTH CARE FINANCING ADMINISTRATION

PAYMENTS TO HEALTH CARE TRUST FUNDS

Table II-1	Budget Authority by Activity	II-3
Table II-2	Amounts Available for Obligation	II-4
Table II-3	Summary of Changes	II-5

PROGRAM MANAGEMENT**MEDICARE CONTRACTORS III-5**

Table III-1	Medicare Contractors' Summary Table	III-5
Table III-2	Medicare Contractors' Funding Summary	III-9
Table III-3	Medicare Contractors' Budget, FY 1997	III-10
Table III-4	Payment Safeguard Administrative Costs, Benefit Savings, and Return on Investment (ROI) ...	III-12
Table III-5	Medicare Contractors' Productivity Investments	III-16
Table III-6	Cost and Workload Comparison	III-18
Table III-7	Appeals Workload, Unit Cost and Total Cost	III-19

STATE SURVEY AND CERTIFICATION III-21

Table III-8	State Survey and Certification Summary Table	III-21
Figure III-1	Growth of Facilities	III-23
Table III-9	Survey and Certification Funding Summary	III-25
Table III-10	Direct Survey Budget Estimates	III-27

**LABORATORY INSPECTIONS UNDER THE
CLINICAL LABORATORY IMPROVEMENT
AMENDMENTS OF 1988****III-35**

Table III-11	CLIA Summary Table	III-35
Figure III-2	CLIA Certified Laboratories by Type	III-36

List of Volume Figures and Tables

RESEARCH, DEMONSTRATIONS AND EVALUATION **III-41**

Table III-12	Research and Demonstrations Summary Table	III-41
Table III-13	Research and Demonstrations Funding Summary	III-47
Table III-14	Congressional Mandates	III-47
Table III-15	Budget by Program Areas	III-48

ADMINISTRATIVE COSTS **III-49**

Table III-16	Administrative Costs Summary Table	III-49
Table III-17	Federal Administration Funding Summary	III-66

SUPPORTING TABLES

Table IV-1	Summary of Changes	IV-1
Table IV-2	Authorizing Legislation	IV-2
Table IV-3	Appropriations History Table	IV-3
Table IV-4	Medicaid Requirements	IV-4
Table IV-5	Budget Authority by Object	IV-5
Table IV-6	Amounts Available for Obligation	IV-6
Table IV-7	Unadjusted State Estimates	IV-7
Table IV-8	Estimates of Grant Awards	IV-8

PAYMENTS TO HEALTH CARE TRUST FUNDS

Table IV-9	Budget Authority by Object	IV-10
Table IV-10	Authorizing Legislation	IV-11
Table IV-11	Appropriations History Table	IV-12
Table IV-12	Funding Levels for Budget Activities	IV-13
Table IV-13	SMI Premium Estimates	IV-14

PROGRAM MANAGEMENT

Table IV-14	Amounts Available for Obligation	IV-15
Table IV-15	Summary of Changes	IV-16

HEALTH CARE FINANCING ADMINISTRATION

Table IV-16	Budget Authority by Activity	IV-17
Table IV-17	Authorizing Legislation	IV-18
Table IV-18	Appropriation History Table	IV-19
Table IV-19	Account Summary	IV-20
Table IV-20	Budget Authority by Object - 2 Year	IV-21
Table IV-21	Budget Authority by Object (CLIA)	IV-23
Table IV-22	Budget Authority by Object - 3 Year	IV-25
Table IV-23	Budget Authority (Administration)	IV-27
Table IV-24	Detail of FTE Employment	IV-28
Table IV-25	HCFA's FTE Ceiling	IV-29
Table IV-26	Detail of Positions	IV-30
Table IV-27	Change of Configuration (Contractors)	IV-31
Table IV-28	State Listing of Intermediaries (Contractors)	IV-32
Table IV-29	Voluntary and Involuntary Terminations (S&C)	IV-35
Table IV-30	Medicare Managed Care	IV-36

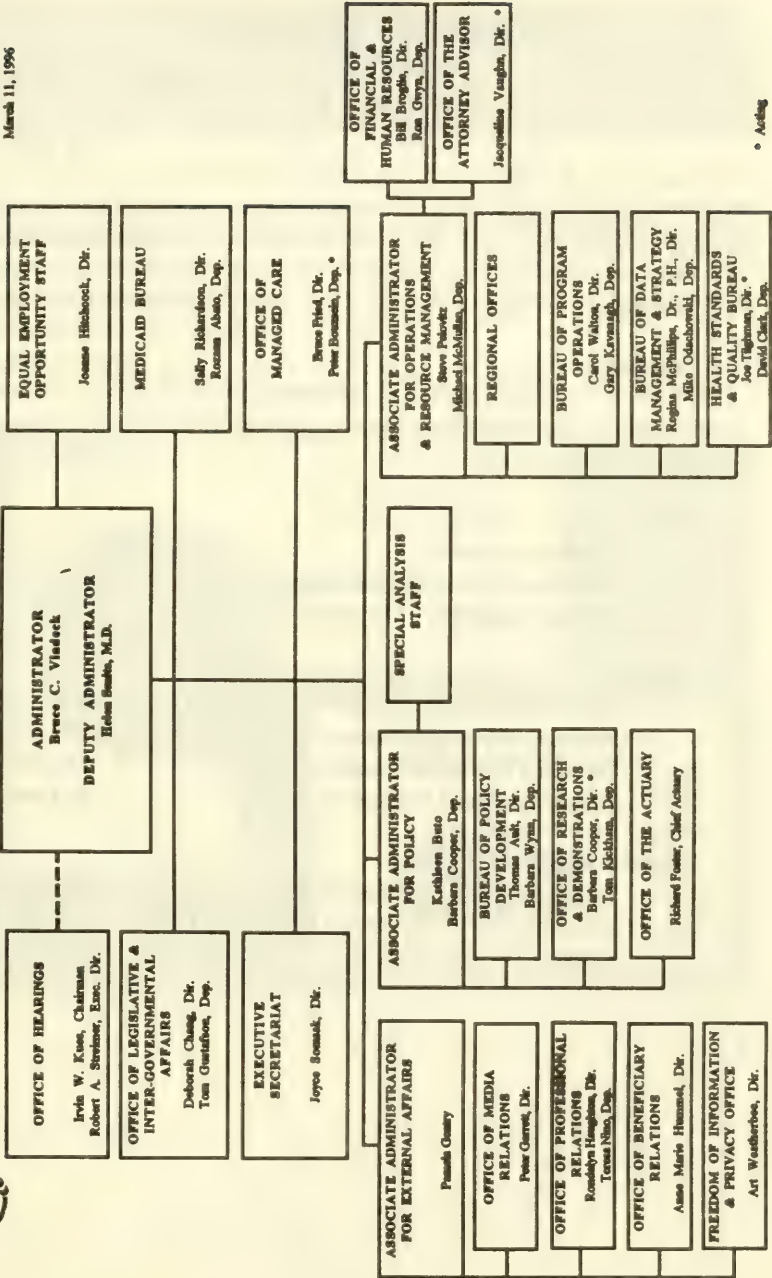
HMO LOAN AND LOAN GUARANTEE FUND

Table IV-31	Amounts Available for Obligation	IV-40
-------------	--	-------

APPROVED
LEADERSHIPAs of
March 11, 1996

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION



Funding Summary

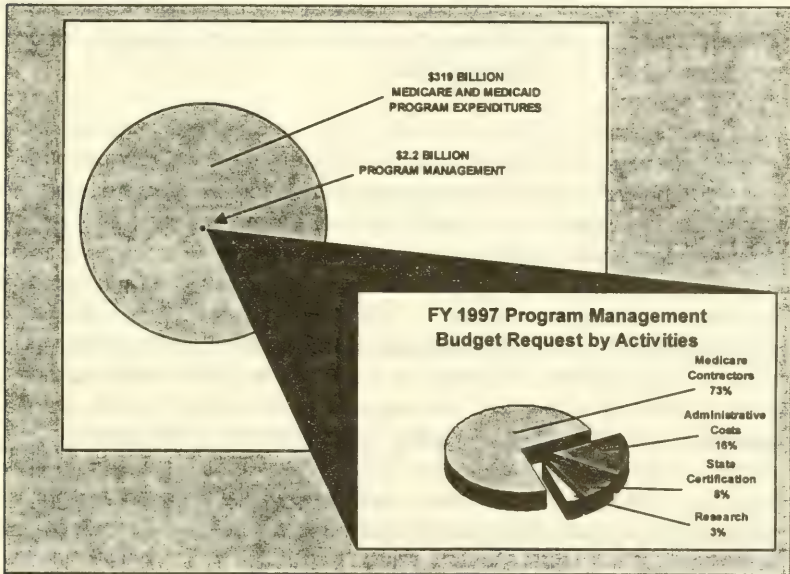
FY 1997

Total Program Expenditures	\$318,903,655,000
Federal Benefits:	\$311,194,144,000
Medicare	\$213,072,158,000
Medicaid	\$98,121,986,000
Federal Operating Costs:	\$7,709,511,000
State Agents:	
Medicaid Agencies	\$4,171,923,000
Survey and Certification Agencies	\$173,800,000
Clinical Laboratory Surveyors	\$43,000,000
Private Sector Agents:	
Intermediaries and Carriers	\$1,614,200,000
Peer Review Organizations	\$269,664,000
Research Contractors and Grantees	\$55,310,000
End-Stage Renal Disease Networks	\$13,842,000
Federal Agencies:	
Social Security Administration	\$918,423,000
HEALTH CARE FINANCING ADMINISTRATION	\$359,106,000
Other (Treasury, OIG, etc.)	\$90,243,000

Putting HCFA in Perspective

HCFA is the largest purchaser of health care in the world. In fiscal year 1997, Medicare and Medicaid program expenditures will be about \$319 billion for 72 million beneficiaries. Under contract with HCFA, 22,000 employees of U.S. insurance companies will pay 860 million Medicare bills, while about 40,000 State employees will oversee payment of about one billion Medicaid bills, as well as processing eligibility claims.

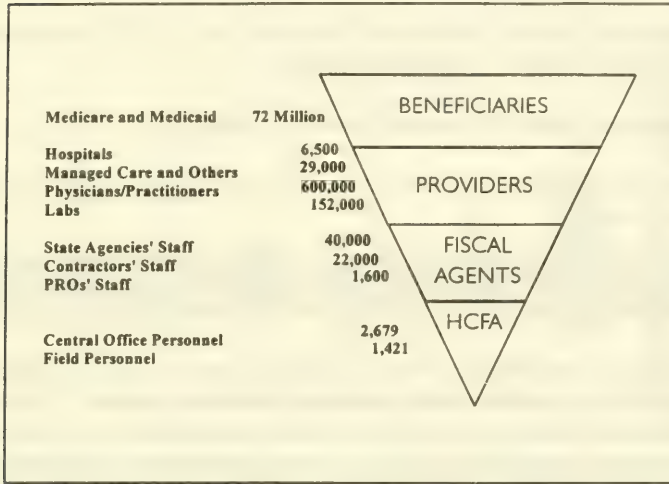
Figure 1 FY 1997 Program Management: Less than 1 Percent of Total Outlays



Budget in Brief

- ▶ 73 percent (\$1.6 billion) of HCFA's 1997 Program Management request of \$2.2 billion will go to 77 private sector Medicare contractors throughout the United States who pay hospitals, physicians, and other health care providers for the care given to Medicare beneficiaries.
- ▶ Of the \$2.2 billion Program Management request, only 16 percent (\$359 million) is to pay for Federal employees and activities (about 1/10th of 1 percent of total projected Medicare and Medicaid outlays).
- ▶ About 8 percent (\$174 million) of the Program Management request supports the inspection of hospitals, nursing homes, home health agencies, and other health care providers. These inspections are performed by about 2,200 State employees in order to assure the safety and quality of health care for Medicare and Medicaid beneficiaries.
- ▶ About 3 percent (\$55 million) funds research and demonstrations, primarily through contracts with private sector researchers, health care providers, and States. HCFA's research and demonstration program emphasizes quality of health care, access to care, the efficiency of delivery and payment systems, and other improvements in the nation's health care system.

The Federal Administration request of \$359 million supports HCFA's staff and operations. Of HCFA's 4,100 full-time equivalent employees (FTEs), about 1,400 work in 10 cities around the country as the front-line people providing direct services to Medicare contractors, State agencies, providers, beneficiaries, and the general public in their areas. Roughly 2,700 of HCFA's FTEs work in the Baltimore, Maryland, and Washington, D.C. area, providing funds to Medicare contractors, developing more efficient operating systems, managing programs to fight fraud, waste, and abuse, monitoring contractor performance and assisting States with Medicaid issues. As the President pointed out in his 1996 State of the Union message, HCFA program integrity activities have resulted in \$15 billion in savings over the last 3 years.

Figure 2 HCFA's Beneficiary-Support Network - 1997

HCFA employees also carry out many other tasks essential to the prudent oversight of Medicare and Medicaid, such as:

- ▶ helping States develop and secure approval for innovative Medicaid policies, and monitor Medicaid spending;
- ▶ managing Medicare and Medicaid health, safety, and quality assurance activities;
- ▶ promoting managed care and monitoring managed care spending and quality of care;
- ▶ ensuring high quality, accurate medical laboratory testing;

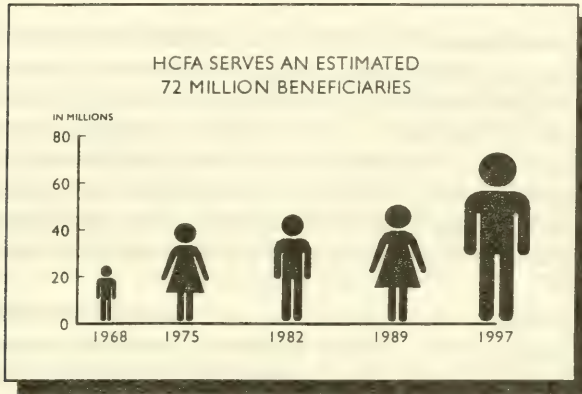
Budget in Brief

- ▶ implementing legislation;
- ▶ providing actuarial, technical and information services to the Congress and helping to respond to constituent inquiries;
- ▶ providing information to beneficiaries and the public;
- ▶ developing budgets, accounting systems, computer systems and many other services.

Budgetary Pressures

While health care expenditures have been increasing at rapid rates, HCFA's program operating costs have actually declined after taking inflation into account. The aging of the population (resulting not only in an increase in program enrollment but also increased use of medical services and thus more claims for payment), increasing numbers of disabled beneficiaries, and a proliferation of providers, such as managed care networks and home health agencies, have all put tremendous pressures on HCFA's operational costs. In spite of these pressures, HCFA has achieved efficiencies which have held Program Management spending virtually level in nominal dollars. Examples include reducing the costs of claims processing and quality surveys, and reducing HCFA staff by 136 FTEs from FY 1993 to FY 1997.

HCFA's search for increased efficiency is becoming more difficult each year as our workload volumes increase and become more complex. The number of Medicare and Medicaid beneficiaries has increased by 11 million since 1992. Over the same period, the number of home health agencies and nursing homes requiring certification has increased by 41 and 22 percent, respectively.

Figure 3 72 Million Beneficiaries Served by HCFA

HCFA's Highest Priorities

- ▶ Resources available for the **Survey and Certification program** remain constrained, but **tremendous growth has occurred in the number of facilities requiring certification**. Inadequate resources for this activity could endanger the health and safety of beneficiaries, and limit HCFA's ability to certify new providers (adversely affecting both the providers and beneficiaries who might need them). Therefore, HCFA is requesting an increase of \$28 million to adequately fund this activity.
- ▶ The **Medicare Transaction System** will consolidate claims processing currently performed by 77 contractors, 9 shared systems and over 60 processing sites into a single unified claims processing system. Although this

Budget in Brief

activity requires up-front funding, it will produce **\$200 million in annual savings by the year 2000.**

- ▶ **Operation Restore Trust:** HCFA, along with the HHS Office of Inspector General, the Administration on Aging, the Department of Justice, and other agencies, has undertaken this health care anti-fraud demonstration. The objective is to demonstrate a team approach in **combating Medicare and Medicaid fraud, waste, and abuse** associated with home health agencies, nursing homes, durable medical equipment suppliers and hospice care. As we learn more about fraud, waste, and abuse, we are focusing our attention across the board on prevention, detection, sanctions, and prosecution.
- ▶ **HCFA On-Line** is a comprehensive communications strategy designed to allow us to respond to **customer information needs with accuracy, speed and flexibility.** Better informed beneficiaries will make better payment plan, provider, and treatment choices.
- ▶ HCFA will also provide all Medicare beneficiaries with a **Medicare handbook** to be sure beneficiaries have the most current information on all aspects of the program.

Strategic Plan

Mission

We assure health care security for beneficiaries

Vision

We guarantee equal access to the best health care

Goals

1. Build a High-Quality, Customer-Focused Team

Medicare and Medicaid beneficiaries are our primary customers, and HCFA increasingly emphasizes customer service. Consistent with this goal, HCFA employees at all levels now lead teams, workgroups, and projects. This approach has allowed us to streamline—a cornerstone of the President's goals of efficiency—as HCFA staff has declined from 4,236 FTEs in FY 1993 to 4,100 FTEs in FY 1997. HCFA has eliminated 242 supervisory positions and pared the number of managers by 47 percent, increasing from six to eleven the average number of employees per manager.

2. Ensure Programs and Services Respond to the Health Care Needs of Beneficiaries

A major priority in FY 1997 will be a universal mailing of the Medicare handbook, providing beneficiaries with the information they need to make informed health care choices. The Medicare handbook is an indispensable source of information on program benefits and policies for beneficiaries.

Our HCFA On-Line initiative will ask beneficiaries to tell us what they want to know, how we should communicate with them, and how well we are responding to them. HCFA On-Line will create communication systems for continuous information exchange between HCFA and its customers.

The Long-Term Care initiative will be beneficiary-focused. This initiative will introduce a variety of flexible long-term care delivery and payment approaches by incorporating beneficiary feedback into the creation of these new approaches.

3. Promote Improved Health Status of Beneficiaries

HCFA will continue reengineering our quality assurance functions to emphasize beneficiary-focused outcome measures, to promote equal access to health care services, and to encourage greater use of preventive care. HCFA seeks to buy quality services in order to improve the health status of our beneficiaries.

The Health Care Quality Improvement Program (HCQIP) emphasizes continual quality improvement of health care. The Peer Review Organizations (PRO) program, which is the focal point of the HCQIP, has now evolved into a proactive effort that develops and promotes best practice guidelines, utilizing an educational approach in partnership with the health care community.

As part of HCFA's Consumer Information Program, we completed a national campaign promoting influenza shots for Medicare beneficiaries prior to the 1995 flu season. HCFA is currently running a major national promotional campaign for mammograms as part of the fight against breast cancer. We are also running, in partnership with the Centers for Disease Control and Prevention, a Flu 2000 campaign to help achieve the goal of a 60 percent flu immunization rate for Medicare beneficiaries by the year 2000. In addition, HCFA has undertaken the Horizons Project, a collaboration between HCFA and historically black colleges and universities in the southeast to develop and implement community-level intervention strategies to improve the health status of African-American Medicare beneficiaries, with initial focus on the use of flu shots.

Because HCFA, along with our partners, has focused its efforts on appropriate care and services for nursing home residents, the proportion of physically restrained residents has been reduced from 40 percent to 20 percent. The inappropriate use of antipsychotic drugs in nursing homes has also declined 59 percent.

In 1997, HCFA will continue its work with the National Committee for Quality Assurance (NCQA) and other key partners to apply the private sector's state-of-the-art HMO performance measurement system—NCQA's Health Plan/Employer Data and Information Set—to the Medicare and Medicaid programs.

4. Be a Leader in Health Care Information Resources Management

Due to the size of the Medicare and Medicaid programs, HCFA's databases represent the Nation's largest and most complete source of health care information. HCFA maintains data on health care utilization for 72 million Medicare and Medicaid beneficiaries, including a wide range of hospital and physician services, delivery arrangements, and consumer demographics. Accordingly, we emphasize ensuring that these data resources are used effectively to improve programs and operations, ensure quality of care, and enable providers and beneficiaries to make informed treatment choices.

For example, HCFA works with the PROs to obtain outcome data to conduct analyses of practice patterns that are then shared with the health care community to improve the quality of care received by beneficiaries. In addition, we have underway several other data improvement activities including our national provider identifier project, State Medicaid research files, fraud and abuse data initiatives, Medicare secondary payer settlement systems, the premium collection system, and the Medicare Current Beneficiary Survey.

HCFA also responds to a growing number of data requests from internal and external sources. Currently, we provide direct access to over 9,000 users including Medicare contractors, State agencies and PROs. On an annual basis, HCFA responds to about 500 requests for public use files, 7,000 Medicare inquiries, 300 requests for custom data files, 1,800 requests for Medicaid data and 200 requests for epidemiological data. Other requests are received from the Congress, 20 other Federal agencies, researchers, beneficiary groups, provider groups, insurance companies, and the news media.

5. Promote Short and Long-Term Fiscal Integrity of Our Programs

Fiscal integrity includes activities to detect and deter Medicare fraud through concerted efforts with the Office of Inspector General, the General Accounting Office, the Department of Justice, and other HCFA partners. This effort resulted in the largest health care fraud settlement in history; a major health care firm that owned over 60 psychiatric hospitals agreed to pay the Federal Government a record \$379 million. HCFA's payment safeguards, administered in partnership with Medicare contractors, are expected to yield savings of \$5.6 billion in FY 1997. Operation Restore Trust, discussed previously, will target the five States with the highest proportion of Medicare (over 33 percent) and Medicaid (40 percent) beneficiaries—New York, Florida, Illinois, Texas, and California.

6. Create Excellence in the Design and Administration of Our Programs

HCFA completed the draft Medicare Transaction System (MTS) Operating Capability document which describes the functions that MTS will support after implementation, starting in 1997. The document also contains the MTS future business requirements that, along with the current MTS requirements, will serve as the basis for the MTS baseline.

Recognizing the increasing growth in the number of managed care plans and in the number of beneficiaries enrolling in such plans, MTS will be capable of tracking beneficiary managed care enrollment and disenrollments, furnishing appropriate information to providers, managing and making capitated payments to managed care plans, and accepting encounter data from managed care plans.

In order to optimize MTS effectiveness, we have developed a legislative proposal to allow HCFA to contract with any qualified company (not just health insurers) to perform current intermediary and carrier functions. Also, HCFA has selected a client-server architecture for MTS and will release a Request for Proposal soon to solicit offers for the MTS operating sites.

7. Provide Leadership in the Continuing Evolution of the Health Care System

HCFA is soliciting a select group of health plans to participate in the Medicare Choices Demonstration, an effort to afford beneficiaries a broad range of options of delivery systems: preferred provider organizations, provider-service networks, open-ended HMOs, point-of-service options, integrated delivery systems, and primary care case management. HCFA will conduct a competitive pricing demonstration which will evaluate cost saving alternatives to payment for managed care. In addition, HCFA will conduct a demonstration which will replace the separate fee-for-service payments for selected surgical procedures with capitated payments for the entire procedure (bundled payments).

HCFA is also continuing to develop ways to improve access in rural areas including the implementation and evaluation of telemedicine demonstrations in five sites. HCFA hopes to collect information that will lead to a payment policy that integrates the increasing capabilities of telemedicine into the Medicare program.

Through the use of 1115 waivers, HCFA has expanded the use of managed care services to Medicaid recipients in more than a dozen states (including high-profile efforts in Oregon and Tennessee). Consequently, some 2.2 million persons, previously uninsured, now receive Medicaid coverage. HCFA has approved 12 comprehensive health care demonstration projects and 24 sub-state Medicaid demonstration projects affecting smaller components of State Medicaid programs. In so doing, we have worked closely with the National Governors' Association to develop general parameters for Medicaid demonstrations and methods of streamlining the application process.

Conclusion

HCFA's FY 1997 request is in line with the two basic objectives of the President's budget: it helps in "protecting the most vulnerable Americans, including senior citizens, working families, and children" but at the same time it reflects restraint and improved efficiencies consistent with achieving a balanced Federal budget in 7 years.

This funding level supports the Federal employees and activities essential to maintaining prudent oversight of the Medicare and Medicaid programs. Equally important, this request would make wise investments in major improvements including MTS, HCFA On-Line and a vigorous program integrity effort.

HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

Table 1 FY 1997 Appropriations Request

	<u>Amount</u>
Grants to States for Medicaid	\$101,192,815,000
Payments to the Health Care Trust Funds	\$60,079,000,000
Program Management	\$2,202,284,000
Health Maintenance Organization Loan and Loan Guarantee Fund	--

*Budget in Brief***Table 2** Summary of Significant Changes in Program Management
Funding Levels

(Dollars in Millions)

	FY 1996 Policy	FY 1997 Request	Difference
Medicare Contractors			
Claims Payment	\$827.2	\$810.8	-\$16.4
Medicare Transaction System	\$20.2	\$75.0	+\$54.8
Contractor Transitions	\$28.5	\$10.0	-\$18.5
Survey and Certification	\$145.8	\$173.8	+\$28.0

Section I Contents

MEDICAID GRANTS TO STATES

Appropriation Language	I-1
Language Analysis	I-2

BACKGROUND OF THE MEDICAID PROGRAM	I-4
--	-----

MEDICAID MANAGED CARE	I-5
------------------------------	------------

SAFEGUARDING HEALTH CARE FOR THE MOST VULNERABLE AMERICANS, GROWING CASELOADS	I-10
--	-------------

SECTION 1115 STATEWIDE WAIVERS	I-14
---------------------------------------	-------------

Fostering Innovative Approaches to Medicaid	I-14
Expanded Coverage to Low-Income Uninsured	I-14
Developed Models for Monitoring Quality	I-15
Evaluated Programs	I-16

BENEFICIARY SERVICES	I-16
-----------------------------	-------------

RATIONALE FOR BUDGET ESTIMATE	I-16
--------------------------------------	-------------

State Estimates for Medical Assistance Payments and State and Local Administration (SLA)	I-16
Medicaid State Survey and Certification	I-17
State Medicaid Fraud Control Units	I-17
Impact of Proposed Legislation	I-17
Per Capita Cap	I-18
Disproportionate Share Hospital (DSH) Payments	I-18
Transition Pools	I-18

List of Section I Figures and Tables

MEDICAID GRANTS TO STATES

Table I-1	Budget Authority by Activity	I-4
Figure I-1	Projected Medicaid Service Growth, FY 1996 - FY 1997	I-7
Table I-2	Projected Benefit Service Growth, FY 1996 - FY 1997	I-9
Figure I-2	The Contribution of Caseloads and Prices to the 7.8 Percent Average Annual Growth in Outlays between FY 1993 and FY 1997	I-10
Figure I-3	Projected FY 1997 Recipients and FY 1997 Outlays by Eligibility Category	I-11
Table I-3	Number of Recipients	I-12
Figure I-4	Medicaid Recipient Growth Rates from FY 1996 - FY 1997	I-13
Table I-4	Medicaid Coverage for the Uninsured Under Section 1115 Waivers	I-15

HEALTH CARE FINANCING ADMINISTRATION
Grants to States for Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, \$75,056,618,000, to remain available until expended.

For making, after May 31, 1997, payments to States under title XIX for the last quarter of fiscal year 1997 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States under title XIX for the first quarter of fiscal year 1998, \$27,988,993,000, to remain available until expended.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, \$75,056,618,000, to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the advance appropriation of \$26.1 billion provided for the first quarter of FY 1997 under the seventh FY 1996 Continuing Resolution (P.L. 104-91). Funds will be used under title XIX for medical assistance payments and State administrative costs and under title XI for demonstrations and waivers.
For making, after May 31, 1997, payments to States under title XIX for the last quarter of fiscal year 1997 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.	This section provides indefinite authority in the last quarter of fiscal year 1997 to meet unanticipated costs.

Medicaid Grants to States

Language Analysis

Language Provision**Explanation**

For making payments to States under title XIX of the Social Security Act for the first quarter of fiscal year 1998, \$27,988,993,000 to remain available until expended.

This section provides an advanced appropriation for the first quarter of fiscal year 1998 to ensure continuity of funding for the Medicaid program in the event a regular appropriation for fiscal year 1998 is not enacted by October 1, 1997.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

This section makes clear that funds are available with respect to State plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

HEALTH CARE FINANCING ADMINISTRATION

Grants to States for Medicaid

Authorizing Legislation - Social Security Act, Title XIX, Section 1901.

(Dollars in Thousands)

Table I-1 Budget Authority By Activity

Medicaid Activity	FY 1996 Policy	FY 1997 Estimate
Medical Assistance Payments	\$90,693,343	\$98,121,986
Administration	4,198,271	4,171,923
Obligations	94,891,614	102,293,909
Unobligated Balance, Start of Year	-12,740,491	-1,101,094
Unobligated Balance, End of Year	1,101,094	0
Budget Authority	\$83,252,217	\$101,192,815

BACKGROUND OF MEDICAID PROGRAM

Title XIX of the Social Security Act assists States in providing medical care to low-income populations.

In general, eligibility for the Medicaid program is automatically linked to eligibility for the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) cash assistance programs. All AFDC and most SSI beneficiaries must be covered under the State Medicaid program. At their option, States may also cover the medically needy. Medically needy recipients are not eligible for SSI or AFDC because they do not meet the income or resource

Medicaid Grants to States

standards, but incur large medical expenses. Medicaid also covers a number of low-income groups including qualified Medicare beneficiaries, pregnant women, infants, and children who meet certain eligibility criteria.

Title XIX requires States to provide a minimum benefit package including hospital inpatient and outpatient services, health screening services to children under 21, physician services, and nursing home care for individuals aged 21 or older. States may also elect to cover additional items such as drugs, dental care, and services in intermediate care facilities. States have considerable flexibility in structuring their programs within broad guidelines established by the Federal Government. Therefore, Medicaid programs can differ greatly from State to State.

Grants for medical assistance are made to States and jurisdictions having Medicaid plans approved by the Department of Health and Human Services. Including the Arizona waiver, there is a Medicaid program in each of the 50 States, the District of Columbia, Puerto Rico and the territories.

Medicaid payments are made directly to the health care provider for services rendered to recipients. Providers must accept the State's payment as full recompense. By law, Medicaid is the payor of last resort. If any other party (including Medicare) is legally liable for services provided to a Medicaid recipient, that party must first meet its financial obligation before Medicaid payment is made.

MEDICAID MANAGED CARE

As of January 1996, section 1915(b) Medicaid managed care ("freedom of choice") waivers are in effect in 42 States. An increasing number of States are rapidly moving their Medicaid populations (mostly AFDC and AFDC-related) into managed care plans. A particular area of growth has been in the area of behavioral health and substance abuse. As of June 30, 1995, more than 32 percent of Medicaid recipients (11.6 million individuals) were enrolled in some form of managed care.

The Omnibus Budget Reconciliation Act of 1981 amended the Social Security Act by adding section 1915(b) which authorizes the Secretary to waive certain provisions of Medicaid law to allow States to develop innovative managed health

HEALTH CARE FINANCING ADMINISTRATION

care delivery or reimbursement systems.

The following statistics highlight this dramatic change into managed care:

- ▶ In 1993, just over 14 percent of Medicaid beneficiaries (4.8 million individuals) were enrolled in managed care programs.
- ▶ In 1994, 33 1915(b) waivers (renewals, modifications, initial requests) received final action by HCFA.
- ▶ In 1995, 58 1915(b) waivers (renewals, modifications, initial requests) received final action by HCFA.
- ▶ As of January 1, 1996, HCFA has approved 14 1915(b) behavioral health or substance abuse waivers in 12 States.

As a result of this trend toward managed care for Medicaid populations, HCFA must increase its efforts to ensure high-quality, cost-effective health care.

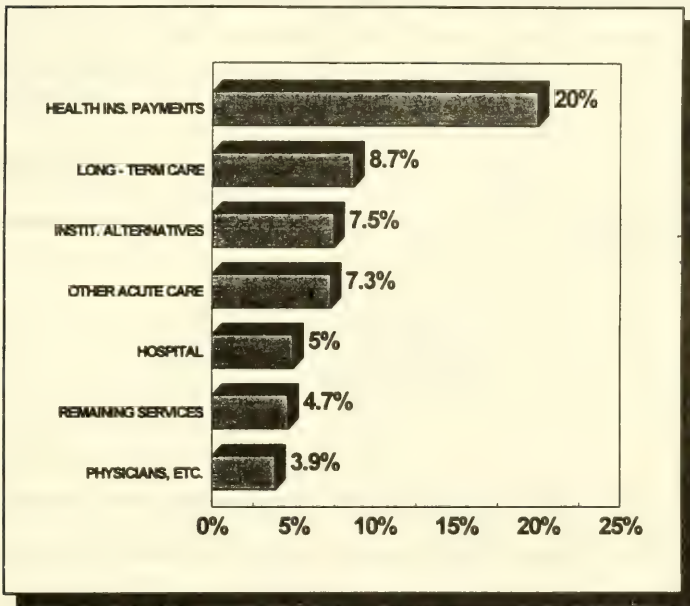
- ▶ **Waiver tracking and information systems**—HCFA is continuing to improve the systems and quality of information it maintains concerning 1915(b) waivers.
- ▶ **Standardize and improve waiver review**—HCFA is working with the regional offices and the Office of Management and Budget to promote standardization and streamlining of 1915(b) review and monitoring.
- ▶ **Coordination with other HHS components**—HCFA will continue coordinating the review of 1915(b) waivers with other HHS components, particularly the Public Health Service, and jointly identify and study important trends and policy issues in Medicaid managed care.
- ▶ **Policy development and technical assistance related to Medicaid managed care**—In conjunction with the States, managed care plans and other organizations, HCFA is developing updated policies and providing

Medicaid Grants to States

technical assistance with the goal of continuously improving Medicaid managed care in areas such as: contract management, enrollment and marketing, fiscal management, quality assurance and improvement, and treatment for the chronically ill, disabled and dual eligible populations.

Medicaid managed care, which makes up most of the health insurance payments service category, is the fastest growing service category in the Medicaid program.

Figure I-1 Projected Medicaid Service Growth, FY 1996 - FY 1997



- The health insurance payments category is projected to grow by 20 percent between FY 1996 and FY 1997. This is more than twice the growth rate of the long-term care service category, which is the second fastest growing service.

The Medicaid health insurance premium category, is comprised primarily of Medicaid managed care insurance premium payments. These premiums are projected to increase by \$2.0 billion from approximately \$10.2 billion in FY 1996 to \$12.2 billion in FY 1997. This \$2.0 billion increase represents 28 percent of the estimated \$7.2 billion total increase in benefit payments.

Managed care's relative contribution to the growth in Medicaid benefit payments is exceeded only by long-term care services. These services are estimated to account for approximately \$2.1 billion, 28.6 percent, of the estimated \$7.2 billion increase in Medicaid benefit payments between FY 1996 and FY 1997.

*Medicaid Grants to States***Table I-2 Projected Benefit Service Growth, FY 1996 to FY 1997****(Dollars in Millions)**

Major Service Category	Dollar Growth	Percent Growth	Percent of Total Growth
Long-Term Care ¹	\$2,062	8.7	28.6
Health Insurance Payments ²	2,018	20.0	28.0
Hospital ³	1,573	5.0	21.8
Other Acute Care ⁴	627	7.3	8.7
Institutional Alternatives ⁵	488	7.5	6.8
Physician/Practitioner/ Dental	240	3.9	3.3
Remaining Services ⁶	206	4.7	2.9
TOTAL	\$7,214	7.9	100.0

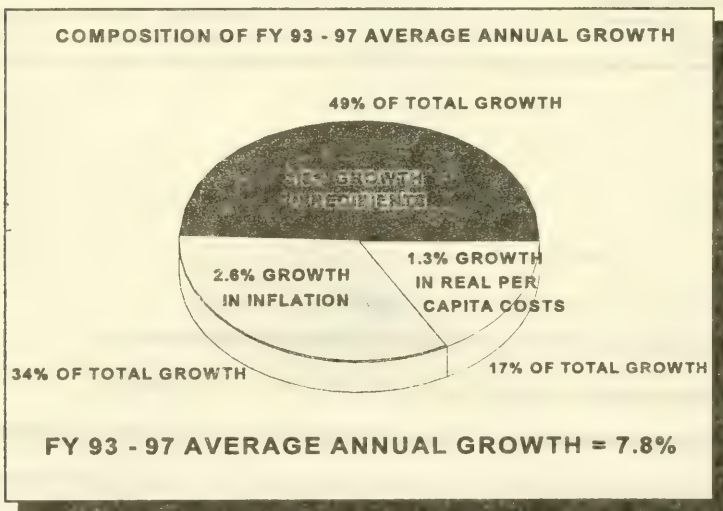
¹ Nursing Facilities, ICFs/MR (intermediate care facilities for the mentally retarded)² Medicare premiums, coinsurance and deductibles, group health and other premiums³ Inpatient and outpatient hospitals, mental health facilities, and disproportionate share hospital payments⁴ Prescription drugs and rebates, lab/x-ray, clinics, rural health clinics, federally-qualified health clinics, early and periodic screening and diagnostic treatment (EPSDT)⁵ Personal care, home health, home and community-based waivers, home and community-based care for the frail and elderly, community-supported living arrangement services⁶ Targeted case management, abortions, sterilizations, hospice, all other services, collections and adjustments

SAFEGUARDING HEALTH CARE FOR THE MOST VULNERABLE RECIPIENTS, GROWING CASELOADS

A significant part of the recent and projected growth in Medicaid program costs is a result of Medicaid recipient increases and price inflation.

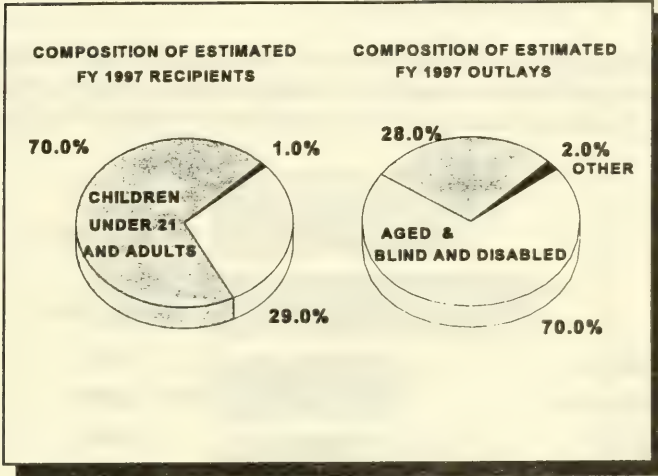
- ▶ Outlays are estimated to grow at an average annual rate of 7.8 percent between FY 1993 and FY 1997. This compares to an average annual growth rate of 21.6 percent during the prior 4-year period from FY 1989 to FY 1993.
- ▶ Annual recipient growth of 3.8 percent accounts for about half of the growth.

Figure I-2 The Contribution of Caseloads and Prices to the 7.8 Percent Average Annual Growth in Outlays Between FY 1993 and FY 1997



Medicaid Grants to States

Figure I-3 Projected FY 1997 Recipients and FY 1997 Outlays
by Eligibility Category



It is projected that in FY 1997, needy adults and children will represent 70 percent of the Medicaid population, but account for only 28 percent of the Medicaid outlays. In contrast, the elderly and disabled population are estimated to make up about 29 percent of the Medicaid population, yet account for approximately 70 percent of the program spending in FY 1997.

Medicaid recipient counts do not reflect the rapidly growing number of uninsured individuals who receive Medicaid health care benefits through section 1115 waivers. These previously uninsured individuals are reflected in Table I-4.

HEALTH CARE FINANCING ADMINISTRATION

The fastest growing segment of the Medicaid population, in annual percentage growth, is the blind and disabled population. These recipients also represent the highest cost Medicaid recipient category.

The following table reflects the estimated annual unduplicated number of recipients (by basis of eligibility) receiving Federal medical assistance under the Medicaid program. The data are based upon the 57 jurisdictions participating in the program.

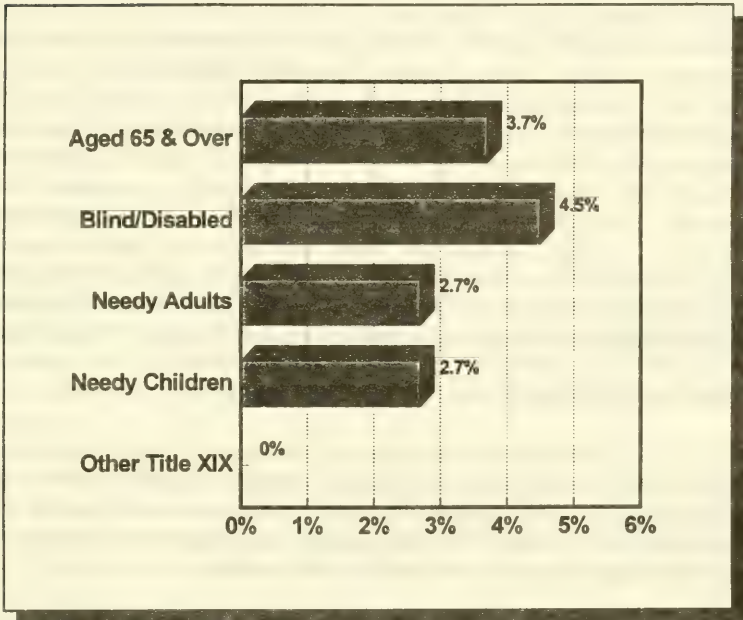
Table I-3 Number of Recipients

(In Thousands)

	<u>FY 1996</u>	<u>FY 1997</u>
Aged 65 and Over	4,389	4,553
Blind and Disabled	6,341	6,626
AFDC Adults	8,041	8,260
AFDC Children	18,169	18,659
Other Title XIX	<u>576</u>	<u>576</u>
Unduplicated Total	37,516	38,674

Estimates of previously uninsured individuals are reflected in table I-4.

Medicaid is projected to provide health care to an increasing percentage of Americans between FY 1996 and FY 2000. According to our projections, during FY 1996, 14.1 percent or an estimated 37.5 million individuals of the estimated 266.1 million U.S. residents will receive Medicaid benefits. This percentage is projected to increase to 15.1 percent, or nearly 1 out of every 7 Americans by FY 2000. The percentages of children in the U.S. and women in the U.S. receiving Medicaid benefits are even higher than these percentages. The following graph displays the Medicaid eligibility growth rates from FY 1996 to FY 1997.

Figure I-4 Medicaid Recipient Growth Rates From FY 1996 to FY 1997

SECTION 1115 STATEWIDE WAIVERS

Fostering Innovative Approaches to Medicaid

Since January 1993, HCFA has approved 12 statewide Medicaid reform demonstrations (Delaware, Florida, Hawaii, Kentucky, Massachusetts, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont), 8 of which are implemented. HCFA is currently reviewing proposals submitted by 10 other States (Alabama, Georgia, Illinois, Kansas, Louisiana, Missouri, New Hampshire, New York, Texas and Utah). Some statewide demonstrations expand access to the uninsured, others test new methods for delivering mental health services and/or services for the disabled, and still others have simplified eligibility requirements. Although the demonstrations vary greatly, many employ a common overall approach: to expand the use of managed care delivery systems for the Medicaid population. Through managed care, States hope to provide improved access to primary care for low-income beneficiaries, along with increased exposure to preventative care measures and health education. In addition, some States hope to use the resulting cost savings to provide health care coverage for the uninsured.

Expanded Coverage to Low-Income Uninsured

HCFA meets its fiduciary responsibilities by requiring that the demonstrations be budget neutral, in that a State's expenditures under the demonstration shall be no more than they would have been without the demonstration. Over the life of the demonstrations, States hope to achieve savings from managed care arrangements to cover additional populations with unmet health care needs.

Through the section 1115 demonstration waiver program, HCFA has encouraged States to expand health care coverage to the low-income uninsured. When all of the 12 currently approved demonstrations are implemented, HCFA estimates that nearly 2.2 million low-income individuals who did not previously receive Medicaid coverage will be eligible for services. (This is in addition to current eligibles and beneficiaries in the long-standing Arizona program.)

*Medicaid Grants to States***Table I-4** Medicaid Coverage for the Uninsured Under Section 1115 Waivers

Uninsured New Recipients	Waiver Status	States*
0.7 million	Implemented	Delaware, Hawaii, Minnesota, Rhode Island, Oregon, Tennessee, Vermont
1.5 million	Approved, Pending Implementation	Florida, Massachusetts

*Oklahoma is implemented but does not expand coverage. Kentucky and Ohio are not implemented and are not expanding coverage.

Developed Models for Monitoring Quality

To maximize what we learn about the effects of projects for future health care reform activities, we have made tremendous strides in developing models for monitoring the quality of care and services. These models include methods of measuring effects on beneficiaries and direct technical assistance to States on data-driven quality monitoring techniques and encounter data. Specific examples include:

- ▶ **Medstat contract**—Medstat will provide technical assistance to States in the areas of encounter data reporting and quality. Medstat will also develop several resource guides, including a guide for States on how to develop and implement an encounter data system and how to use that system to monitor quality.
- ▶ **GeoAccess**—HCFA has purchased software to monitor access and provider capacity in demonstrations.

Evaluated Programs

We have awarded three 5-year contracts to evaluate 11 of the implemented demonstrations. Each evaluation will utilize onsite visits by the evaluators and is designed to examine the impacts of the demonstrations on: the expansion eligibles; the number of uninsured and underinsured individuals in the State; improved access; quality, including health status, process of care, and satisfaction; and the cost of services.

BENEFICIARY SERVICES

Qualified Medicare Beneficiary (QMB) Outreach

HCFA conducts computer matches of Social Security Administration and HCFA files designed to identify people who may be eligible for the QMB benefit. Based on the matches, HCFA provides identified beneficiaries with information by mail on what the income levels are needed to qualify for the program and where to apply if they believe they are eligible. This outreach activity has increased the number of enrolled QMBs, and has provided them with a Federal Government contact to which to address their Medicaid-related issues.

RATIONALE FOR BUDGET ESTIMATE

State Estimates for Medical Assistance Payments and State and Local Administration (SLA)

Estimates of the Federal share of Medicaid costs are based on the spending projections submitted by the States during November 1995. These estimates have been adjusted only to reflect savings due to Medicaid financial reviews conducted by the HCFA regional office staff and the costs of funding the Vaccines for Children program. For FY 1997, the Federal share of medical assistance payments and State and local administration are estimated to be \$102.0 billion. This represents an increase of 7.8 percent above the estimated FY 1996 level.

Medicaid State Survey and Certification

The current FY 1997 Federal Financial Participation estimate for Medicaid State Certification is \$163.1 million. This increase of \$9.1 million above the current FY 1996 estimate of \$154 million reflects a 5.9 percent growth rate.

In FY 1997, an estimated 7,800 Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) will be surveyed, an increase of 300 ICF/MRs over FY 1996. In addition, 12,900 nursing facilities (NFs) that participate as dually-participating Medicare/Medicaid NFs are projected to be surveyed in FY 1997, an increase of approximately 760 NFs over FY 1996. The cost of surveying NFs is shared equally between the Medicare and Medicaid programs. In FY 1997, it is projected that 2,900 Medicaid-only NFs will be surveyed.

State Medicaid Fraud Control Units

This appropriation provides funds for establishing and operating State Medicaid fraud control units which identify, investigate, and prosecute cases of fraud, abuse or patient neglect. These units also make recommendations to the State Medicaid agencies on corrective actions. In FY 1996 and FY 1997, 47 fraud control units will be in operation at a projected cost of \$79.0 and \$82.0 million, respectively.

Impact of Proposed Legislation

The President's proposal preserves the guarantee of health and long-term care coverage for the most needy individuals. This plan is projected to save \$59 billion over 7 years. These savings will be accomplished responsibly, by limiting spending on a per-person basis and reducing disproportionate share hospital payments and retargeting them to hospitals serving large numbers of Medicaid and uninsured patients.

► ***Per Capita Cap***

A per capita cap limits Federal spending growth per person while retaining current eligibility and benefit guidelines. This approach guarantees that the elderly, people with disabilities, and pregnant women and children who depend on Medicaid will remain eligible for health benefits while reducing the growth rate in spending.

► ***Disproportionate Share Hospital (DSH) Payments***

This proposal reduces DSH payments and retargets them to hospitals that serve a large proportion of Medicaid and uninsured patients, including children's and public hospitals.

► ***Transition Pools***

Three capped pools of Federal funds are designated for payments to specific states and providers to help them transition from the current to the new Medicaid program.

In addition, the budget proposes a number of policies to give States more flexibility in managing their Medicaid programs, such as:

Boren Amendment. Repealing the so-called "Boren Amendment," eliminating Federal provider payment requirements for hospitals and nursing homes.

Managed Care. Allows States to enroll beneficiaries in managed care without Federal waivers.

Medicaid Grants to States

Home and Community-Based Care. Allows States to move populations who need long-term care from nursing homes to home and community-based settings, without having to seek Federal waivers.

Coverage Expansions without Waivers. Enables States, without waivers, to expand coverage to any person whose income is less than 150 percent of the poverty line.

Section II Contents

PAYMENTS TO HEALTH CARE TRUST FUNDS

Appropriation Language	II-1
General Statement	II-2

List of Section II Tables

PAYMENTS TO HEALTH CARE TRUST FUNDS

Table II-1	Budget Authority by Activity	II-3
Table II-2	Amounts Available for Obligation	II-4
Table II-3	Summary of Changes	II-5

Payments to Health Care Trust Funds

HEALTH CARE FINANCING ADMINISTRATION
Payments to the Health Care Trust Funds**Appropriation Language**

For payment to the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as provided under sections 217(g) and 1844 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, \$60,079,000,000.

Payments to Health Care Trust Funds**GENERAL STATEMENT**

This account includes four general fund payments to the Health Care Trust Funds.

The largest of these payments is made to the Federal Supplementary Medical Insurance (SMI) Trust Fund. This payment is the Federal match of premiums paid by or for individuals voluntarily enrolled in Part B of Medicare. The Part B premium is currently set to cover 25 percent of the estimated incurred costs for aged beneficiaries. The Federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining costs of both the aged and disabled.

In FY 1997, the Federal match is estimated to be \$59,456,000,000. This amount represents 99 percent of the requested appropriation for Payments to the Health Care Trust Funds.

The other three general fund payments in this account are made to the Hospital Insurance (HI) Trust Fund. Two of these payments compensate the HI Trust Fund for the benefit and administrative costs of two uninsured groups: persons aged 65 years and above who were grandfathered into the program at its inception and Federal annuitants grandfathered into the program after 1982. A third payment to the HI Trust Fund finances administrative expenses previously financed by a general fund appropriation to HCFA's Program Management account. In FY 1997, the three payments in total are estimated to be \$623,000,000.

*Payments to Health Care Trust Funds***Table II-1** Budget Authority by Activity

(Dollars in Thousands)

	1995 <u>Actual</u>	1996 <u>Policy</u>	1997 <u>Estimate</u>
Supplementary Medical Insurance	\$36,955,000	\$61,331,000	\$59,456,000
Hospital Insurance for the Uninsured	406,000	358,000	405,000
Hospital Insurance for Uninsured Federal Annuitants	56,000	61,000	76,000
Program Management Administrative Expenses	<u>129,758</u>	<u>149,000</u>	<u>142,000</u>
Total Budget Authority	\$37,546,758	\$61,899,000	\$60,079,000

HEALTH CARE FINANCING ADMINISTRATION

Table II-2 Amounts Available for Obligation

	1995 <u>Actual</u>	1996 <u>Policy</u>	1997 <u>Estimate</u>
Appropriation:			
Annual	\$37,546,758,000	\$61,899,000,000	\$60,079,000,000
SMI Shortfall (non-add)	[6,735,906,000]		
Payback of SMI shortfall (including interest) (non-add)	_____	[6,966,662,000]	_____
Total Obligations	\$37,546,758,000	\$61,899,000,000	\$60,079,000,000

*Payments to Health Care Trust Funds***Table II-3 Summary of Changes**

1996 Policy	\$61,899,000,000
1997 Estimate	<u>\$60,079,000,000</u>
Net Change	-\$1,820,000,000

	1996 Current Estimate Base <u>Budget Authority</u>	1997 Change <u>From Base</u>
Changes:		
1. Federal Payment for Supplementary Medical Insurance	\$61,331,000,000	-\$1,875,000,000
2. Hospital Insurance for the Uninsured	358,000,000	+47,000,000
3. Hospital Insurance for Uninsured Federal Annuitants	61,000,000	+15,000,000
4. Program Management Administrative Expenses	<u>149,000,000</u>	<u>-7,000,000</u>
Net Change	\$61,899,000,000	-\$1,820,000,000

Section III Contents

PROGRAM MANAGEMENT

Appropriation Language	III-1
Language Analysis	III-2
GENERAL STATEMENT	III-4

MEDICARE CONTRACTORS

III-5

Authorizing Legislation	III-5
PRIORITIES FOR FY 1997	III-5
Medicare Benefit Integrity System	III-5
Medicare Transaction System	III-6
Control Medicare Expenditures	III-7
Improve Customer Service	III-7
Reduce Administrative Costs	III-7
Support Managed Care	III-8
Improved Beneficiary and Provider Services	III-8
RATIONALE FOR THE BUDGET REQUEST	III-9
Payment Safeguards	III-11
Medicare Secondary Payer (MSP) Legislation	III-13
Productivity Investments	III-13
Medicare Transaction System	III-13
Contractor Transitions	III-14
Administrative Simplification	III-14
Improve Beneficiary and Provider Services	III-14
National Provider Identification	III-15
Claims Processing	III-16
Bill/Claims Payment	III-16
Reimbursement	III-17
Beneficiary and Provider Services	III-19
Appeals	III-19
Beneficiary Communications and Provider Education and Training	III-20

HEALTH CARE FINANCING ADMINISTRATION

Participating Physician and Supplier Program	III-20
STATE SURVEY AND CERTIFICATION	III-21
BACKGROUND OF THE STATE SURVEY	
CERTIFICATION PROGRAM	III-21
Growth of Facilities	III-22
Health Care Quality Improvement Program	III-23
Enforcement	III-25
RATIONALE FOR THE BUDGET ESTIMATE	III-28
Direct Survey Activities	III-28
Unit Cost Budget Methodology	III-30
SUPPORT CONTRACT ACTIVITIES	III-31
Review for Psychiatric Conditions at Hospitals	III-31
Psychiatric Hospital Surveys:	
Special Conditions	III-31
Redesign of the Survey Process	III-32
Maintenance and Enhancement of State's	
Clinical Databases	III-32
Redesign Survey Protocols	III-32
Minimum Data Set Centralized Database	III-32
Develop Test and Validate Quality Indicators (QIs)	
For Health Care Facilities	III-33
Training	III-33
Change to Surveyor Training Program	III-33
Satellite Training Network	III-33
Program Evaluation and Oversight	III-34
Investing in Improved Efficiency	III-34
Outcome and Assessment Information Set—	
Data Infrastructure and Support System	III-34

LABORATORY INSPECTIONS UNDER THE CLINICAL

Program Management

LABORATORY IMPROVEMENT AMENDMENTS OF 1988	III-35
Authorizing Legislation	III-35
BACKGROUND OF THE CLIA PROGRAM	III-35
User Fees	III-37
Current Findings	III-37
Methods of Correction	III-38
RATIONALE FOR THE STATE SURVEY BUDGET ESTIMATE	III-38
RESEARCH, DEMONSTRATIONS AND EVALUATIONS	III-41
Authorizing Legislation	III-41
BACKGROUND	III-41
Accomplishments	III-42
FY 1997 INITIATIVES	III-44
Monitoring and Evaluating Health System Performance	III-44
Improving Health Care Financing and Delivery Mechanisms	III-45
Meeting the Needs of Vulnerable Populations	III-46
Improving Consumer Choice and Health Status	III-46
ADMINISTRATIVE COSTS	III-49
Authorizing Legislation	III-49
BACKGROUND	III-49
RATIONALE FOR THE BUDGET REQUEST	III-50
Medicare	III-50
Claims Payment	III-51
Beneficiary Services	III-52
Market Research	III-53
Provider and Beneficiary Outreach	III-53
Electronic Information Support	III-53
Quality Assurance	III-55
Program Integrity and Management	III-57
Medicaid	III-60
	III-iii

HEALTH CARE FINANCING ADMINISTRATION

Program Payments to States	III-60
Beneficiary Services	III-61
Quality Assurance	III-62
Partnership with States	III-64

List of Figures and Tables

PROGRAM MANAGEMENT

MEDICARE CONTRACTORS

III-5

Table III-1	Medicare Contractors Summary Table	III-5
Table III-2	Medicare Contractor's Funding Summary	III-9
Table III-3	Medicare Contractor's Budget, FY 1997	III-10
Table III-4	Payment Safeguard Administrative Costs, Benefit Savings, and Return on Investment (ROI)	III-12
Table III-5	Medicare Contractors' Productivity Investments	III-16
Table III-6	Cost and Workload Comparison	III-18
Table III-7	Appeals Workload, Unit Cost and Total Cost	III-19

STATE SURVEY AND CERTIFICATION

III-21

Table III-8	State Survey and Certification Summary Table	III-21
Figure III-1	Growth of Facilities	III-23
Table III-9	Survey and Certification Funding Summary	III-25
Table III-10	Direct Survey Budget Estimates	III-27

LABORATORY INSPECTIONS UNDER THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

III-35

Table III-11	CLIA Summary Table	III-35
Figure III-2	CLIA Certified Laboratories by Type	III-36

RESEARCH, DEMONSTRATIONS AND EVALUATION

III-39

Table III-12	Research and Demonstrations Summary Table	III-41
Table III-13	Research and Demonstrations Funding Summary	III-47

III-v

 HEALTH CARE FINANCING ADMINISTRATION

Table III-14 Congressional Mandates	III-47
Table III-15 Research Obligations by Program Areas	III-48

ADMINISTRATIVE COSTS	III-49
-----------------------------	---------------

Table III-16 Administrative Costs Summary Table	III-49
Table III-17 Federal Administration Funding Summary	III-66

HEALTH CARE FINANCING ADMINISTRATION
Program Management

Appropriation Language

For carrying out, except as otherwise provided, titles XI, XVIII, and XIX of the Social Security Act, title XIII of the Public Health Service Act, the Clinical Laboratories Improvement Amendments of 1988, section 4360 of Public Law 101-508, and section 4005(e) of Public Law 100-203, not to exceed \$2,202,284,000 together with all funds collected in accordance with section 353 of the Public Health Service Act, the latter funds to remain available until expended; the \$2,202,284,000 to be transferred to this appropriation as authorized by section 201(g) of the Social Security Act, from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds: Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the Public Health Service Act are to be credited to and available for carrying out the purposes of this appropriation.

HEALTH CARE FINANCING ADMINISTRATION

Language Analysis

Language Provision

Explanation

For carrying out, except as otherwise provided, titles XI, XVIII, and XIX of the Social Security Act, title XIII of the Public Health Service Act, the Clinical Laboratories Improvement Amendments of 1988, section 4360 of Public Law 101-508, and section 4005(e) of Public Law 100-203, not to exceed \$2,202,284,000, together with all funds collected in accordance with section 353 of the Public Health Service Act, the latter funds to remain available until expended;

Provides funding for the administration of the Medicare and Medicaid programs and total funding for the Clinical Laboratories Improvement Amendments (CLIA) program. The CLIA program is funded solely from user fees collected and these collections are available to be carried over from year to year.

the \$2,202,284,000 to be transferred to this appropriation as authorized by section 201(g) of the Social Security Act, from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds:

Funding for the administration of the Medicare and Medicaid programs is transferred from the HI and SMI Trust funds. The HI Trust Fund will be reimbursed for the Federal Funds allocation of these costs through an appropriation in the Payments to the Health Care Trust Funds account.

Program Management

Language Analysis

Language Provision

Explanation

Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the Public Health Service Act are to be credited to and available for carrying out the purposes of this appropriation.

Authorizes the crediting of HMO user fee collections to the Program Management account.

HEALTH CARE FINANCING ADMINISTRATION

GENERAL STATEMENT

HCFA was established in 1977 to bring together, under the auspices of one Agency, the management of two major Federal programs: Medicare and Medicaid. The mission of HCFA is to ensure health care security for beneficiaries.

In FY 1997, the HCFA Program Management appropriation estimate includes the current law requirements in the following activities, which are integral to the accomplishment of the agency mission:

- ▶ **Medicare Contractors**, which process Medicare claims, conduct payment safeguard activities, and provide information to beneficiaries and providers on reimbursement, coverage, eligibility, and other program requirements.
- ▶ **State Survey and Certification** which ensures that institutions and agencies providing health care services to Medicare and Medicaid beneficiaries meet Federal health, safety, and program standards.
- ▶ **Research, Demonstrations, and Evaluation** projects which are designed to improve the organization, delivery, quality, and financing of health care services.
- ▶ **Administrative Costs**, which include personnel and other operating costs of the agency.

Non-Appropriated Program Management activities include:

- ▶ **Laboratory Inspections**, which ensure that all laboratories that test human specimens for health purposes, including physicians' offices, meet Federal health, safety, and quality standards.
- ▶ **Peer Review Organizations**, which are the primary means of ensuring high-quality care for Medicare beneficiaries, primarily through cooperative projects with the provider community.

The President's appropriation request of \$2.2 billion for this account represents current law requirements. No proposed law amounts are included.

*Program Management***Medicare Contractors**

Authorizing Legislation - Social Security Act, Title XVIII, Sections 1816 and 1842, 42 U.S.C. 1395.

Table III-1 Medicare Contractors' Summary Table

	FY 1995 Appropriation	FY 1996 Policy	FY 1997 Estimate	Increase or Decrease
Total Obligations	\$1,604,171,000	\$1,604,171,000	\$1,614,200,000	+\$10,029,000
Contractor Full-time Equivalents (FTEs)	23,768	23,000	22,000	-1,000

Medicare contractors discharge the government's responsibility for paying Medicare providers and suppliers for health services delivered in a timely, accurate, and fiscally responsible manner. In addition to paying submitted claims, fiscal intermediaries and carriers act as a link to HCFA's programs by responding to provider and beneficiary inquiries and appeals. They are also the frontline in safeguarding the Medicare Trust Funds against fraud and abuse.

PRIORITIES FOR FY 1997

HCFA is taking aggressive steps to improve the administration of the Medicare program. These activities are essential for reducing administrative costs as well as ensuring the fiscal integrity of the Medicare Trust Funds. The following investments are being made in order to improve HCFA's ability to administer the Medicare program.

Medicare Benefit Integrity System

HCFA is accelerating its efforts against waste, fraud, and abuse in the Medicare program. In order to stabilize the funding for payment safeguards, the President has

proposed, in separate legislative recommendations, the Medicare Benefit Integrity System (MBIS). Under MBIS, HCFA would establish specialized, multi-year contracts for program integrity activities. At present, funding for HCFA program integrity activities is subject to the variability of the budget process making it difficult for HCFA to invest in innovative strategies to control fraud and abuse. This instability also makes it difficult for our contractors to attract, train, and retain qualified professional staff, including auditors, health professionals, and fraud investigators.

MBIS will establish a dependable and permanent source of funding for HCFA's anti-fraud and abuse activities by supporting them through the Medicare Trust Funds. This proposal will allow HCFA to invest in new and innovative approaches to combat fraud and abuse. MBIS will allow HCFA to pursue strategies that shift emphasis from post-payment recoveries on fraudulent claims to pre-payment strategies designed to ensure that claims are paid correctly the first time. Experience has shown that investment in anti-fraud and abuse activities yields a high return.

In order to control Medicare fraud and abuse, HCFA will need more than just stable funding for its payment safeguard activities. HCFA will need to utilize advanced technologies to mine its vast information resources. At the forefront of HCFA's productivity investments is just such a system. The Medicare Transaction System (MTS) will provide HCFA with a means of reducing Medicare fraud and abuse while enhancing the efficiency and consistency of its claims payment systems.

Medicare Transaction System

In an effort to simplify programs and improve administration, HCFA began the design of MTS in FY 1994. MTS is not just a claims processing system, but, an information management system which will support the insurance choices that Medicare beneficiaries will be offered.

Program Management

Current Medicare contractor computer and telecommunications systems, as well as HCFA systems supporting managed care, are fragmented, old, non-responsive, and costly. MTS will re-engineer these systems. The end result will be one modern, distributed client server architecture that will be flexible, expandable and capable of continuous technological enhancements as new hardware, software, and network capabilities are developed. MTS will help HCFA improve the control of Medicare expenditures, improve customer service to beneficiaries and providers, lower administrative costs, and accommodate alternative health care delivery arrangements, such as, managed care options.

► ***Control Medicare Expenditures***

MTS will improve HCFA's capability to detect fraud and abuse, identify suspicious billing patterns and aberrancies, bring about early trend detection, and take action to prevent payment for inappropriate claims. MTS, in conjunction with MBIS, will provide HCFA with the tools necessary to reduce the levels of fraud, waste, and abuse in the Medicare program.

► ***Improve Customer Service***

MTS will improve services to beneficiaries and providers by supporting a single point of contact for information on entitlement, eligibility, benefits, payment decisions, and claims status. MTS will also greatly enhance the coordination of supplemental insurance benefits by automatically sending claims data to other insurers for their share of payment without additional beneficiary and/or provider involvement.

► ***Reduce Administrative Costs***

In addition to program benefits, MTS will provide significant administrative cost savings when fully implemented in FY 2000. HCFA will begin to phase-in MTS in FY 1997, and conclude the transitions in the fall of 1999. During the transition years of FY 1997 and FY 1998, MTS will require

start-up and transition expenditures. The anticipated cost for FY 1997 is \$75 million, an increase of \$54.8 million from FY 1996. However, this investment will be offset by \$200 million in annual savings by the end of calendar year 1999.

► ***Support Managed Care***

With MTS, HCFA will have an increased ability to efficiently manage an increasing number of Medicare managed care plans. For example, MTS will:

- Track beneficiary managed care enrollments and furnish appropriate information to providers;
- Manage and make capitated payments to managed care plans; and,
- Accept encounter data from managed care plans.

Additional information on MTS processing can be found in the Productivity Investments section of this chapter.

Improved Beneficiary and Provider Services

Moving forward to implement MTS, HCFA will simultaneously review its other business processes and initiate the appropriate re-engineering efforts. The first step in this process is the implementation of the Medicare Summary Notice (MSN). The MSN will convert separate Part A and Part B notices, formerly called the Explanation of Medicare Benefits, into a single, standardized, easy-to-understand benefits summary. It will also have a direct positive impact on approximately 39 million beneficiaries annually. The MSN will reduce the cost of printing and mailing multiple notices and will serve as a reference point for beneficiary inquiries. Direct improvements to the notice include a prominent customer service information box containing telephone numbers for beneficiaries to use in contacting service representatives, special fraud alerts and other informational messages, a simplified, easy-to-read notes section, and an area to request an appeal.

Focus group testing has been conducted on a national level and beneficiaries have expressed great satisfaction with the MSN. HCFA will begin mailing out the MSN to beneficiaries in FY 1997.

RATIONALE FOR THE BUDGET REQUEST

Within the Medicare program, contractors perform a multitude of tasks essential to ensuring that beneficiary and provider needs are met. Ongoing Medicare contractor activities include: payment safeguards, claims and bill payment, provider reimbursement, productivity investments, beneficiary and provider services (including appeals, beneficiary communication, and provider education and training) and the participating physician and supplier program.

Table III-2 displays the funding and contractor FTE levels for the past 5 years.

Table III-2 Medicare Contractors' Funding Summary

Fiscal Year	Appropriation 1/	Contractor FTE
1992	\$1,714,000,000	28,051
1993	\$1,600,362,000	26,607
1994	\$1,615,300,000	25,614
1995	\$1,604,171,000	23,768
1996	\$1,604,171,000	23,000

1/ In FY 1992, funding for Medicare contractor budget included a contingency fund of \$257,000,000, of which \$76,180,000 was released.

Table III-3 compares the policy level for FY 1996 and the FY 1997 request for Medicare contractors. Following Table III-3 is a more detailed discussion of the ongoing program.

HEALTH CARE FINANCING ADMINISTRATION

Table III-3 Medicare Contractors' Budget, FY 1997
(Dollars in Millions)

	<u>FY 1996 Policy</u>	<u>FY 1997 Estimate</u>	<u>Increase or Decrease</u>
Payment Safeguards			
Medical & Utilization Review	\$115.0	\$115.0	\$0.0
Benefit Integrity	34.9	\$34.9	0.0
Audit and Provider Settlement	148.0	148.0	0.0
Medicare Secondary Payer	<u>98.4</u>	<u>98.1</u>	<u>-0.3</u>
Total Payment Safeguards 1/	\$396.3	\$396.0	-\$0.3
Productivity Investments	\$71.6	\$115.0	+\$43.4
Claims Processing			
Bill/Claims Payment	\$827.2	\$810.8	-\$16.4
Reimbursement	39.8	\$36.6	-3.2
Printing	<u>1.8</u>	<u>2.0</u>	<u>+0.2</u>
Total Claims Processing	\$868.8	\$849.4	-\$19.4
Beneficiary & Provider Services			
Hearings	\$81.8	\$77.8	-\$4.0
Beneficiary Communications	137.2	138.3	+1.1
Provider Education	<u>23.5</u>	<u>20.5</u>	<u>-3.0</u>
Total Beneficiary & Provider Services	\$242.5	\$236.6	-\$5.9
Participating Physicians	\$25.0	\$17.2	-\$7.8
TOTAL BUDGET	<u>\$1,604.2</u>	<u>\$1,614.2</u>	<u>+\$10.0</u>

1/ Passage of the Medicare Benefit Integrity System (MBIS) as proposed will provide an additional \$44 million in FY 1996 and \$104 million in FY 1997 for payment safeguards. MBIS would shift funding for payment safeguards from HCFA's discretionary administrative budget to a mandatory program under the Medicare Trust Funds.

Payment Safeguards

HCFA must take every opportunity to redesign and upgrade program operations and data systems to eliminate the fraudulent activities of parties trying to take advantage of program dollars and beneficiaries. It is for this reason that HCFA will continue to emphasize computer technology and our partners' abilities to utilize data systems to identify and monitor services that may be vulnerable to abuse. By identifying abusive patterns of services, HCFA prevents future problems. One key to the detection of Medicare fraud and abuse will be the MTS. MTS will allow us to identify national trends in fraudulent or abusive activities associated with the Medicare program—trends that can be immediately analyzed and acted upon.

Although the number of providers and the volume of claims continue to increase, HCFA has been successful in its oversight of the Medicare program. Payment safeguards are expected to save \$5.6 billion in FY 1997. These estimates are based on a ratio of approximately \$14 in Medicare savings for each \$1 invested in payment safeguards.

Payment safeguard functions include conducting medical reviews of claims to determine whether services are medically necessary and constitute an appropriate level of care; deterring and detecting Medicare fraud; auditing provider cost reports; and assuring that Medicare acts as a secondary payer when a beneficiary has primary coverage through other insurance. Table III-4 displays the administrative costs, benefit savings, and a return on investment for each payment safeguard activity.

HCFA has also signed an interagency agreement with the Los Alamos National Laboratory (LANL) to develop prepayment software that will detect and deter improper claims, including service code manipulations. LANL is using several sets of advanced analytical techniques for fraud, waste, and abuse detection which they have recently applied to government programs that are similar to Medicare. Many of these techniques rely on artificial intelligence to identify medically unnecessary or fraudulent claims before they are paid. This is a unique opportunity because many of the resources (i.e., personnel and equipment) necessary to support operation of these techniques do not exist outside LANL.

HEALTH CARE FINANCING ADMINISTRATION

Table III-4 Payment Safeguard
Administrative Costs, Benefit Savings, and Return on Investment (ROI)
 (Dollars in Millions)

	FY 1996			FY 1997		
	<u>COST</u>	<u>SAVINGS</u>	<u>ROI</u>	<u>COST</u>	<u>SAVINGS</u>	<u>ROI</u>
MR/UR						
Part A	\$33.1	\$297.9	9:1	\$33.0	\$297.9	9:1
Part B	<u>81.9</u>	<u>819.0</u>	10:1	<u>82.0</u>	<u>819.0</u>	10:1
Subtotal	\$115.0	\$1,116.9	10:1	\$115.0	\$1,116.9	10:1
Benefit Integrity	\$34.9		1/	\$34.9		1/
Audit	\$148.0	\$1,480.0	10:1	\$148.0	\$1,480.0	10:1
MSP						
Part A	\$42.5	\$2,176.3	51:1	\$42.5	\$2,210.0	52:1
Part B	<u>55.9</u>	<u>839.0</u>	15:1	<u>55.6</u>	<u>834.0</u>	15:1
Subtotal	\$98.4	\$3,015.3	31:1	\$98.1	\$3,044.0	31:1
Total	\$396.3	\$5,612.2	13:1	\$396.0	\$5,640.9	14:1

1/ The implications of the changes in scope and nature of activities make it difficult to quantify savings for Benefit Integrity.

Medicare Secondary Payer (MSP) Legislation

MSP is designed to identify situations where insurers other than Medicare are the primary payer. However, a recent court case has limited the time period that HCFA has to initiate collections from primary insurers. The decision also prevents HCFA from collecting overpayment from third-party administrators who manage self-insured plans. A preliminary assessment indicates that the court decision may reduce the return on investment for the MSP program from 35:1 in FY 1994 to 31:1 in FY 1997. As a result of this assessment, HCFA estimates that MSP savings will be reduced by \$400 million in FY 1996 and \$570 million in FY 1997. HCFA has developed a legislative proposal that would restore some of the lost savings.

Productivity Investments

HCFA is taking aggressive steps to implement investment strategies which are designed to improve the administration of the Medicare program. The following productivity investments will improve HCFA's ability to administer the Medicare program. At the forefront of HCFA's productivity investments is the Medicare Transaction System (MTS).

► *Medicare Transaction System*

As mentioned earlier in this chapter, MTS is HCFA's information management system which will support the insurance choices that the Medicare beneficiary will be offered. The MTS project has recently reached a significant milestone. HCFA has selected the system architecture of the MTS system. Moreover, HCFA is developing a Request for Proposal (RFP) which will solicit bids for the MTS operating sites. The RFP will be released in the spring of 1996. The RFP will be available through the Internet.

MTS operating sites will be designed for efficient, high-volume transaction processing and prompt inquiry response. Given the possibility that processing and storage capacity requirements could increase in the future, HCFA is prepared to establish additional processing centers, should they be necessary. The RFP will provide detailed information regarding system architecture.

The MTS hardware architecture will have three tiers. High throughput mainline transaction processing and data management will be done by powerful mainframe computers. Users will access MTS services with intelligent desktop workstations employing window-style graphical interfaces. The mainframes and desktops will be tied together as a single system through communications servers that will manage the flow of information and work throughout the system.

The software will use underlying "middleware" and data management software to enable a layered approach that separates applications from the actual data stores. This will allow HCFA to continually consider application improvements and even use commercial off-the-shelf software for some functions.

► ***Contractor Transitions***

One of the major costs in moving to the MTS environment is the cost associated with contractor transitions. Currently, HCFA maintains contracts with 77 contractors (44 Fiscal Intermediaries - Part A, 29 Carriers - Part B, and 4 Durable Medical Equipment Regional Carriers). HCFA foresees several contractors voluntarily opting out of the Medicare program in FY 1997. Funding is requested for non-renewals and transition costs associated with these changes.

► ***Administrative Simplification***

Administrative simplification involves standardization of the contractor systems for the processing of claims and related provider and beneficiary activities. Contractor systems for interfacing with MTS will be standardized and made more efficient with state-of-the-art telecommunications and information systems technologies. In addition, HCFA will only support Medicare contractor enhancements that move us closer to implementation of MTS or that are the result of legislative changes.

► ***Improve Beneficiary and Provider Services***

Several efforts will be undertaken to improve beneficiary and provider services. The most significant plan is to implement a Medicare Summary Notice (MSN), which was previously discussed.

Program Management

▶ ***National Provider Identification***

In preparation of MTS, HCFA will assign a National Provider Identifier to all health care providers. This initiative will allow HCFA to standardize Medicare and Medicaid provider enumeration data to assist our benefit integrity efforts, and provide our health care industry partners with standard enumeration capabilities.

Table III-5 displays the funding for the productivity investments for FY 1996 and FY 1997.

HEALTH CARE FINANCING ADMINISTRATION

Table III-5 Medicare Contractors' Productivity Investments

(Dollars in Millions)

Activity	FY 1996	FY 1997	Increase or Decrease
MTS	\$20.2	\$75.0	+\$54.8
Contractor Transitions	28.5	10.0	-18.5
Administrative Simplification	17.5	17.9	+0.4
Improve Beneficiary and Provider Services	3.2	\$11.1	+7.9
National Provider Identification	2.2	1.0	-1.2
TOTAL	\$71.6	\$115.0	+\$43.4

Claims Processing

Claim processing functions include the costs associated with paying Part A and Part B claims, including: electronic data processing, contractor personnel costs, postage, printing, etc. Claims processing funding accounts for approximately 53 percent of the money requested in Medicare contractors.

Bill/Claim Payment

The funding level required to ensure Medicare contractors pay all correctly submitted claims for FY 1997 is \$810.8 million, which is a decrease of \$16.4 million from FY 1996. The costs associated with claims processing will continue to decrease as HCFA continues to increase contractor operating efficiencies. HCFA estimates that Line 1 unit costs will decrease by approximately 5 percent from FY 1996 to FY 1997.

Medicare contractors will process an estimated 861.4 million claims, 154.6 million for Part A and 706.8 million for Part B, an increase of 3.5 percent in FY 1997 from FY 1996. These estimates take into account the increase in Medicare managed care enrollment which currently stands at 3.9 million beneficiaries. In FY 1997, HCFA estimates that 6.1 million beneficiaries will choose a managed care alternative to the traditional fee-for-service plan.

The growth in managed care is the result of health maintenance organizations expanding their marketing efforts to include Medicare beneficiaries. HCFA expects that Medicare managed care enrollment will grow at a rate of approximately 25 percent per annum.

Despite increases in managed care, fee-for-service claims volumes continue to increase. Table III-7 shows unit cost and workload data related to claims processing. Historical data is provided for both tables for FY 1993 through FY 1995. In addition, projections are provided for FY 1996 and FY 1997.

► ***Reimbursement***

Provider reimbursement services include establishing and adjusting interim rates, collecting provider overpayments, and providing consultative services to providers for maintaining their accounting systems.

HEALTH CARE FINANCING ADMINISTRATION

Table III-6 Cost and Workload Comparison

Bottom-Line Unit CostsIN CURRENT DOLLARS

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
Part A	\$2.61	\$2.45	\$2.29	\$2.20	\$1.98
Part B	\$1.60	\$1.52	\$1.42	\$1.40	\$1.35

IN CONSTANT 1988 DOLLARS

Part A	\$2.12	\$1.95	\$1.78	\$1.67	\$1.47
Part B	\$1.30	\$1.21	\$1.11	\$1.06	\$1.00

Line 1 Unit Costs—Claims Processing OnlyIN CURRENT DOLLARS

Part A	\$1.50	\$1.40	\$1.33	\$1.30	\$1.25
Part B	\$0.96	\$0.89	\$0.94	\$0.85	\$0.80

IN CONSTANT 1988 DOLLARS

Part A	\$1.22	\$1.11	\$1.04	\$0.99	\$0.93
Part B	\$0.78	\$0.71	\$0.73	\$0.65	\$0.59

Workload in Millions

	<u>FY 1993</u>		<u>FY 1994</u>		<u>FY 1995</u>	
	Part A	Part B	Part A	Part B	Part A	Part B
Receipts	110.3	573.2	121.1	612.7	134.1	643.0
Processed	109.6	574.9	120.6	615.1	133.1	646.5
	<u>FY 1996</u>		<u>FY 1997</u>			
	Part A	Part B	Part A	Part B		
Receipts	144.8	687.9	154.6	706.8		
Processed	144.8	687.9	154.6	706.8		

Program Management

Beneficiary and Provider Services

Beneficiary and provider services include fee-for-service appeals, beneficiary communications, and the provider education and training program.

► ***Appeals***

Beneficiaries, providers, physicians, and suppliers are entitled by law to appeal the initial determination made by Medicare contractors. There are various levels of appeal that are conducted by carriers and fiscal intermediaries. Carriers conduct reviews and hearings for Part B claims. Fiscal intermediaries conduct reviews, reconsiderations, and hearings for Part A claims. Table III-7 provides the actual workload, unit costs, and total costs associated with processing fee-for-service appeals for FY 1995 and estimates for FY 1996 and FY 1997.

Table III-7 Appeals Workload, Unit Cost and Total Cost

	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
<u>Workload</u>			
Part A	247,335	229,600	230,000
Part B	7,716,367	7,296,800	7,300,000
Total	7,963,702	7,526,400	7,530,000
<u>Unit Costs</u>			
Part A	\$44.07	\$46.17	\$43.86
Part B	\$8.81	\$9.76	\$9.27
Average	\$9.91	\$10.87	\$10.33
<u>Total Costs in Millions</u>			
Part A	\$10.9	\$10.6	\$10.1
Part B	\$68.0	\$71.2	\$67.7
Total	\$78.9	\$81.8	\$77.8

► ***Beneficiary Communications and Provider Education and Training***

The Medicare contractors link beneficiaries and providers to the Medicare program. HCFA, in concert with the contractors, continues to strive towards offering the most effective and efficient service to beneficiaries and providers and continues to expand their awareness and understanding of the Medicare program.

Participating Physician and Supplier Program

The goal of this initiative is to reduce the impact of escalating medical costs on beneficiaries by increasing the participation rates of physicians and suppliers. In addition, the Participating Physician and Supplier Program enforces the charge limit. In fact, for the first time since 1986, when billing caps were imposed, HCFA has initiated investigations and is pursuing actions against physicians who violate the charge limit. The charge limit is currently 115 percent of approved rates. This proactive stance is the result of legislation passed in FY 1995 which broadened and clarified HCFA's authority to sanction physicians who violate the limiting charge compliance requirements.

As stated previously, the major priorities within the Medicare contractor budget are payment safeguards, the Medicare Transaction System, and beneficiary and provider communications. HCFA's major priorities in conjunction with its ongoing activities will improve Medicare administration and lower administrative and program costs.

State Survey and Certification

Authorizing Legislation - Social Security Act, Title XVIII, Section 1864.

Table III-8 State Survey and Certification Summary Table

	FY 1995 Appropriation	FY 1996 Policy	FY 1997 Estimate	Increase or Decrease
Survey & Certification	\$141,800,000	\$140,800,000	\$164,800,000	+\$24,000,000
Support Contracts	\$4,000,000	\$5,000,000	\$9,000,000	+\$4,000,000
Total Obligations	\$145,800,000	\$145,800,000	\$173,800,000	+\$28,000,000

BACKGROUND OF THE STATE SURVEY AND CERTIFICATION PROGRAM

The State Survey and Certification program ensures that institutions and agencies providing health care services to our beneficiaries meet Federal health, safety, and program standards.

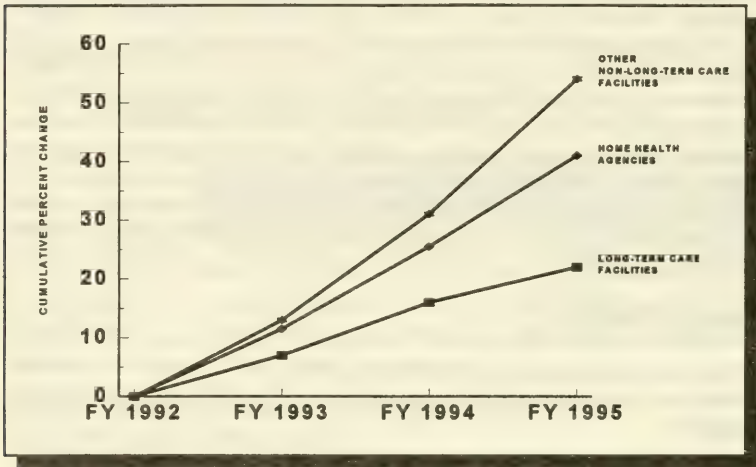
HCFA's quality oversight extends not only to hospitals but also to nursing homes, home health agencies (HHAs), end-stage renal disease (ESRD) facilities, hospices, and all other facilities where services are provided to Medicare and Medicaid beneficiaries. HCFA's investment in quality oversight includes initial inspections of providers and suppliers who request participation in the Medicare program, annual recertification inspections of nursing homes and HHAs as required by law, and periodic recertification inspections of other health care providers and suppliers. Additionally, HCFA requires that complaint allegations, including allegations of patient dumping, be investigated within 3 weeks of notification.

The States received 94 percent of the funds appropriated for survey and certification activities, with the remaining 6 percent dedicated to support contracts. Serving as agents of HCFA, the State survey agencies inspect providers and suppliers on HCFA's behalf to determine their compliance with Federal health, safety, and program standards. If the State surveyors find that a provider or supplier has deficiencies that do not seriously jeopardize resident or patient health and safety, the providers develop a plan of correction. The State surveyors then conduct followup visits as necessary to ensure that the deficiencies are corrected in a timely manner. Should the noncompliance with program requirements pose an immediate and serious threat to resident or patient health and safety, HCFA will move for immediate program termination of the provider or supplier.

Growth of Facilities

HCFA has experienced an extraordinary growth in the number of facilities entering the Medicare and Medicaid programs over the past 3 years. Recent data indicate a:

- ▶ 22 percent increase in the number of nursing homes from FY 1992 to FY 1995;
- ▶ 41 percent increase in the number of HHAs;
- ▶ 54 percent increase in the number of other non-long-term care facilities, including hospitals, ESRD facilities, and others; and,
- ▶ 193 percent increase in the number of rural health clinics.

Figure III-1 Growth of Facilities

Health Care Quality Improvement Program

HCFA understands the necessity to enforce critical health and safety standards in order to improve the care provided to beneficiaries.

- ▶ This commitment is reflected in the Health Care Quality Improvement Program, the Agency's approach to assuring and improving the quality of care it purchases. As part of this program, HCFA is revising the conditions of participation for hospitals, HHAs, and ESRD facilities. The revisions will place greater emphasis on the provider's responsibility to monitor outcomes and on effective internal quality management systems. For example, standards that specify the format and content of medical records or the availability of dietary manuals are requirements that need not be mandated and monitored by an external body if the provider's quality management system is effective

HEALTH CARE FINANCING ADMINISTRATION

in doing so. It is our intent to eliminate process and structural requirements, wherever possible, as methods for measurement of outcomes become more effective and more readily used by health care providers.

- ▶ Revised survey processes that reinforce these changes are now in place for HHAs, dialysis facilities, and nursing homes. We will be retraining surveyors across the country to strengthen their capability to focus on patient outcomes. The focus on outcomes considerably strengthens external quality management efforts by giving important information to providers for use in their quality improvement programs. For virtually all of our survey processes, we will be continuing to develop quality indicators that focus very heavily on patient outcomes rather than on the organization and activities of the provider. The net result is improved quality throughout the program. In FY 1997, HCFA will continue to develop these quality indicators focusing on patient outcomes.

In an aggressive effort to offset the costs associated with these increases, HCFA is concentrating on reducing variances in the per survey unit costs of the State agencies. From FY 1993 to FY 1996, HCFA made significant progress—a reduction of 48 percent in the variance of State agencies per survey costs in the non-long-term care surveys. During that same period, HCFA accomplished a reduction of 36 percent in the variance of costs in the long-term care arena. This is an ongoing effort that must continue through FY 1997.

Program Management

Funding for the past five years was as follows.

Table III-9 Survey and Certification Funding Summary

Fiscal Year	Appropriation
1992	\$150,000,000
1993	\$148,009,000
1994	\$145,800,000
1995	\$145,800,000
1996	\$145,800,000

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) expanded and strengthened HCFA's enforcement responsibilities in nursing homes and HHAs, and imposed sanctions such as denial of payment for new admissions, temporary management, or civil monetary penalties. Standard surveys of these providers must be conducted on an average of once per year.

Enforcement

Between FY 1993 and FY 1995, there were 2,559 voluntary and 218 involuntary terminations.

- ▶ Voluntary terminations include providers and suppliers that withdraw from program participation rather than face expulsion. In addition, HCFA sends several hundred termination notices to providers and suppliers each year who manage to correct problems in time to avoid termination.
- ▶ Currently, 72 percent of nursing homes are failing to meet health and safety requirements and 13 percent are found to be providing substandard quality of care. However, 96 percent of all facilities come

into substantial compliance by completion of the revisit. An example of the danger inherent in a reduced level of enforcing health and safety requirements is illustrated by the fact that during their most recent survey, 8.5 percent of the Nation's 2,833 ESRD facilities were found to have deficiencies in the proper analysis and treatment of water used for dialysis, which can have serious implications for patient health.

To ensure that States are conducting surveys in accordance with explicit criteria and instructions, a pool of Federal surveyors performs monitoring surveys. These surveyors are located in each of HCFA's 10 regional offices. HCFA provides States with the results of their monetary surveys as part of the regional office oversight and quality assurance activities. Federal surveyors also provide the technical assistance to implement any recommended improvements to the survey process.

*Program Management***Table III-10 Direct Survey Budget Estimates****FY 1997****MEDICARE STATE CERTIFICATION**

Facility Type	Universe Start of the Year	New Facilities	FY 1997 Universe	Recert Coverage	Recert Surveys	Total Surveys
SNF XVIII	1,361	126	1,487	100%	1,361	1,487
SNF XVIII/XIX	12,848	759	13,607	100%	12,848	13,607
HHA	9,872	798	10,670	100%	9,872	10,670
Non-Accredited	1,428	21	1,449	25%	357	378
Accredited	4,958	0	4,958	5%	248	248
Others	<u>14,081</u>	<u>1,541</u>	<u>15,622</u>	25%	<u>3,520</u>	<u>5,061</u>
Total	44,548	3,245	47,793		28,206	31,452

Facility Type	Surveys	Unit Cost	Budget
SNF XVIII	1,487	\$13,008	\$19,342,896
SNF XVIII/XIX*	13,607	\$13,008	\$88,499,928
Hospital	626	\$3,516	\$2,200,664
HHA	10,670	\$3,511	\$37,462,370
Others	<u>5,061</u>	\$2,875	<u>\$14,551,142</u>
Subtotal	31,452		\$162,057,000

Other Direct Costs \$2,743,000

Total Direct Survey \$164,800,000

Costs

* Reflects Medicare's 50 percent share. The remaining 50 percent is funded by Medicaid.

Note: Numbers are rounded.

RATIONALE FOR THE BUDGET ESTIMATE

The FY 1997 estimate for direct survey activities and related contracts to support and improve the survey process is \$173.8 million. This includes \$164.8 million for survey activities, an increase of \$24.0 million over the FY 1996 appropriation, and \$9 million for support contracts, \$4 million more than the FY 1996 appropriation. This increase of \$24 million is necessary to support the level of growth in the number of facilities in the Survey and Certification program. Even with the efficiencies HCFA has implemented, the workload outstrips the budget.

Direct Survey Activities

The funding for direct survey activities consists of \$164.8 million. Included in this funding is one of HCFA's top priorities, to survey all initial providers and suppliers requesting participation in the Medicare program. The majority of the funds required for survey activities, \$145.3 million or 84 percent of the total survey activity budget, is earmarked to fulfill statutory mandates to survey all nursing facilities, and all HHAs. This mandate also includes investigating all allegations of patient dumping in FY 1997. The breakout of the \$145.3 million is as follows:

- ▶ Initial inspections of more than 1,600 facilities expected to request Medicare program participation during FY 1997. This will eliminate the backlog of initial surveys.
- ▶ Annual inspections of all nursing homes and HHAs on an average of once per year—a coverage level of 100 percent.
- ▶ Inspections of all allegations of patient dumping. HCFA estimates approximately 1,000 investigations of dumping complaints in FY 1997.

Program Management

The remaining \$16.8 million in direct Federal survey activities will consist of more than 1,600 initial surveys, validation of accredited hospitals, recertification surveys for all other facility types which are discretionary. HCFA will conduct recertification surveys on 25 percent of these facility types, which include:

- ▶ Non-accredited hospitals,
- ▶ Non-accredited psychiatric hospitals,
- ▶ End-stage renal disease (ESRD) facilities,
- ▶ Hospices,
- ▶ "Others," such as ambulatory surgical centers, rural health clinics, outpatient therapies, comprehensive outpatient rehabilitation facilities, portable x-ray providers, organ procurement organizations, etc.

The direct survey estimates also provide for the following ongoing direct survey-related activities and items that are essential to maintain the surveys throughout the year:

- ▶ Printing of the survey report forms used by State surveyors to document their findings during the survey and followup processes;
- ▶ Printing of the survey and certification manual issuances and transmittals for HCFA regional offices and for State survey agencies, and training packets each surveyor must have to conduct surveys and followup activities;
- ▶ Satellite transmission time to conduct the training courses necessary to ensure that surveyors perform surveys in a consistent and uniform manner nationwide; and,

HEALTH CARE FINANCING ADMINISTRATION

- ▶ Rental of the phone lines (the Value Added Network) that transmit survey agency findings to the HCFA database.

Unit Cost Budget Methodology

HCFA develops cost projections for survey and certification workloads by means of the unit cost budget methodology. Through this methodology, funds are allocated to the States' survey agencies based on survey time and survey coverage level parameters. States are paid based on payment guidelines regarding the length of the different surveys for the various provider types and the incidence of resurveying providers already participating in the Medicare and/or Medicaid programs.

Recognizing the need to maximize available Federal resources for the State Survey and Certification program, HCFA convened a workgroup of HCFA and State survey agency personnel. This workgroup has:

- ▶ Refined unit cost budget methodology;
- ▶ Recommended options for improvement;
- ▶ Conducted an analysis of State expenditure patterns as compared to workload and survey time parameters in an effort to identify high-cost States and factors attributable to variances in State costs;
- ▶ Accepted two independent variables in the unit cost budget calculations: State-mandated civil service pay rates and survey travel requirements. State-mandated civil service pay rates, incorporating a range of surveyor disciplines, were collected from each State and consolidated into a database of State salaries. Statistical survey travel data, collected from the On-Line Survey and Certification Reporting System, will be utilized to determine acceptable travel variances for each State; and,

Program Management

- ▶ Established a database combining State costs with State survey data, from which unit cost calculations may be tabulated and State spending patterns may be closely monitored.

The efforts of the workgroup over the past year, and its focus on the unit cost budget methodology, has led to a decrease in the projected costs in four of the five facility types. For example, the unit cost for a dually-participating skilled nursing facility has decreased from \$14,793 in FY 1994 to \$13,008 in FY 1997. The workgroup will continue its efforts to develop sound and efficient national survey times by collecting and applying data on optimal time parameters for each survey element as derived from the pilot tests of the revised long-term care survey process.

SUPPORT CONTRACT ACTIVITIES

Survey and certification support contracts, funded at a level of \$9 million for FY 1997, will address four different areas:

- ▶ ***Review for Conditions at Psychiatric Hospitals***

Psychiatric Hospital Surveys: Special Conditions (\$960,000)

This contract gives HCFA access to psychiatric clinical professionals by drawing from a nationwide pool of experts. The contractor will be responsible for providing expert mental health consultants (including psychiatrists), scheduling and conducting surveys and providing technical assistance and consultation to providers, HCFA regional office staff and State agencies.

► ***Redesign of the Survey Process***

Maintenance and Enhancement of State's Clinical Databases (\$2,000,000)

HCFA expects to have in place by FY 1997, a standardized system in all States for the automated collection of minimum data set (MDS) data from nursing homes. The budget request for FY 1996 allocated funds for the establishment of this infrastructure. After the basic structure is in place, HCFA will need to support the States in maintaining this data system.

Redesign Survey Protocols (\$960,000)

HCFA will continue in its aggressive efforts to redesign the survey processes for virtually all of its certified providers and suppliers. HCFA will revise the survey system for long-term care providers by incorporating quality indicators derived from the MDS data system. This will require testing and validating the revised survey system in FY 1997.

Minimum Data Set Centralized Database (\$720,000)

After the MDS databases are established in all States, HCFA will expand and maintain the centralized data system. This system is needed for HCFA's regional offices to have access to MDS data to monitor the States' survey performance; to develop and test quality indicators to conduct research on best practices; to create and maintain a consumer information access system; and to use in health policy decision making.

**Develop Test and Validate Quality Indicators (QIs)
for Health Care Facilities (\$1,360,000)**

HCFA plans to use QIs as the core in its efforts to improve the health and well-being of persons receiving care through providers and suppliers under the Medicare and Medicaid programs. QIs are valid measurements of the care provided so that internal as well as external quality assurance processes are effectively directed toward improvement of care.

► ***Training***

Changes to Surveyor Training Program (\$1,000,000)

In FY 1997, activities will focus on startup efforts and include collecting baseline data, awarding a contract for the development of core performance behaviors, continuing the process of standardizing curricula for any new courses developed plus some recurring courses; piloting the results; and beginning the design work for the data and quality assurance systems.

Satellite Training Network (\$700,000)

The satellite video-conference network will better facilitate HCFA communications with regions, provider and supplier communities, consumer groups and other partners in the health care industry and the training of State and Federal surveyors by providing a uniform presentation through the wide distribution of information available through a satellite network.

► ***Program Evaluation and Oversight***

Investing in Improved Efficiency (\$300,000)

HCFA is continuing its aggressive efforts to reduce the unit costs of surveys conducted by State survey agencies through refinements to the funds allocation methodology it employs. Currently, the divergence of States' survey cost estimates indicates the continuation of some inefficiencies. In order to address these inefficiencies, HCFA has strongly focused its attention on States' survey times, staffing ratios, and unit costs. In conjunction with these efforts, HCFA initiated a study in FY 1995 to derive independent time utilization estimates of the revised long-term care survey process. HCFA anticipates the need to expand this study to include other provider types, especially HHAs and hospitals.

**Outcome and Assessment Information Set—
Data Infrastructure and Support System (\$1,000,000)**

During FY 1997, HCFA will be implementing the final version of conditions of participation for HHAs that will include the requirement that HHAs utilize a core standard assessment data set, called the Outcome and Assessment Information Set (OASIS). The OASIS includes about 80 valid and reliable quality indicators developed over a 5-year period by the University of Colorado for use in quality assessment and performance improvement efforts. In order for the OASIS to be used in a national data set that can be compiled, analyzed and made available to a wide variety of end users, HCFA must utilize a data system platform on which to mount the system. HCFA intends to build on the system being developed for similar purposes in nursing homes.

Laboratory Inspections under the Clinical Laboratory Improvement Amendments of 1988

Authorizing Legislation - Public Health Service Act, Title XIII, Section 353.

Table III-11 CLIA Summary Table

	FY 1995 Actual	FY 1996 Policy	FY 1997 Estimate	Increase or Decrease
User Fee Obligations	\$33,638,000	\$37,000,000	\$43,000,000	+\$6,000,000

BACKGROUND OF THE CLIA PROGRAM

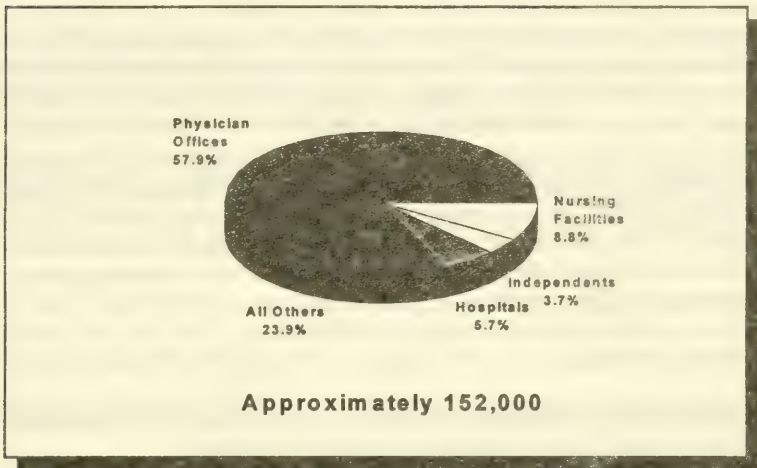
The Clinical Laboratory Improvement Amendments of 1988 (CLIA) ensure all laboratories that test human specimens for health purposes, including those in physicians' offices, meet Federal health, safety, and quality standards.

An estimated 152,000 laboratories are currently registered with the CLIA program. Approximately 57 percent of these laboratories are classified as waived or provider performed microscopy laboratories, meaning they are not subject to a routine onsite inspection. The most significant population of the laboratories registered under the CLIA program is physician office laboratories (POLs). Approximately 59 percent of the POLs are waived or provider performed microscopy laboratories. Other facility types having laboratories subject to CLIA include: hospitals, nursing facilities, independent laboratories, end-stage renal disease facilities, ambulatory surgical centers, rural health clinics, insurance laboratories, and Federal, State, city and county laboratories. Laboratories exempt from routine Federal inspections include those performing only waived tests, laboratories in which specified practitioners do only certain microscopic tests, laboratories accredited by approved accrediting organizations,

HEALTH CARE FINANCING ADMINISTRATION

and laboratories in States that approve or license clinical laboratories under standards at least as stringent as CLIA. Laboratories which are accredited or in exempt States are inspected by the accrediting organization or State at the same frequency as HCFA certified laboratories. The organizations and States have been determined to have standards which are equivalent to CLIA.

Figure III-2 CLIA Certified Laboratories by Type



CLIA provisions are based on the complexity of tests, not the type of laboratory where the testing occurs. Thus, laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other site.

The first cycle of inspections for the CLIA laboratories was completed in March 1995 in every State in the country. The second cycle of inspections will be completed by March 1997. The CLIA program's findings attest to the need for continued vigilance in the monitoring of the quality of laboratory testing.

Over 80 percent of the laboratories inspected have had deficiencies in one or more areas, and more than 10 percent of the facilities had serious deficiencies which could potentially cause health risk to patients.

User Fees

The CLIA program is a 100 percent user-fee financed program. Costs have been reduced to ensure a positive cash-flow in the CLIA account. HCFA realized early in 1992 that anticipated revenues would not support the projected costs of CLIA and aggressively began to identify and implement procedures to reduce the costs of the program. Both HCFA and its CLIA partner, the Centers for Disease Control and Prevention (CDC), have successfully reduced Federal administration costs. The agencies have streamlined administrative activities resulting in the need for fewer full-time equivalent (FTE) employees than originally anticipated. Additionally, both HCFA and CDC have ceased all hiring under the CLIA program. HCFA has also limited the travel and equipment costs needed to administer the program. By achieving efficiencies in the inspection process, HCFA has substantially cut compliance activity costs, without negatively impacting the CLIA program.

Current Findings

Initial CLIA surveys identified more deficiencies in physician office laboratories (POLs) than in any other clinical laboratories. For example:

- ▶ 35 percent of POLs failed to adequately assess whether tests were producing accurate results, compared to 23 percent of hospital laboratories and 13 percent of independent laboratories;
- ▶ 28 percent of POLs failed to follow test manufacturers' instructions, compared to 20 percent of hospital laboratories and 11 percent of independent laboratories;

HEALTH CARE FINANCING ADMINISTRATION

- ▶ 9 percent of POLs failed to check the reliability of materials used to culture and identify disease-causing bacteria, compared to 4 percent of hospital laboratories and 2 percent of independent laboratories; and,
- ▶ 8 percent of POLs failed to ensure reliable identification of patient specimens, compared to 4 percent of hospital laboratories and 3 percent of independent laboratories.

Methods of Correction

After finding a laboratory out of compliance with CLIA requirements, HCFA has several sanctions it can impose upon the laboratory. They include suspension or revocation of the CLIA certificate, civil monetary penalties, directed plan of correction, and suspension of all or part of Medicare payments.

However, HCFA's approach to CLIA compliance is primarily educational, giving labs feedback about quality problems and recommending solutions. Our main goal is to assist laboratories and make quality improvements leading to more accurate test results and better patient care.

The data shows that this approach is working, especially with physician office laboratories. Of those physician office laboratories that have undergone two surveys, compliance rates more than doubled in the second cycle survey.

RATIONALE FOR THE STATE SURVEY BUDGET ESTIMATE

The CLIA budget development methodology is based upon the number of CLIA laboratories, the levels of State agency survey performance and workloads, and survey costs. HCFA determines national State survey workloads by taking the total number of laboratories, excluding waived laboratories, laboratories issued certificates of provider performed microscopy, State-exempt laboratories, and accredited laboratories. HCFA then sets the national State survey workload at 100 percent of the laboratories to be inspected in a 2-year cycle. Workloads for each cycle include a 3 to 5 percent sample review of the 18,600 accredited laboratories, surveys of 40,000 non-accredited laboratories, and 7 percent complaint/followup surveys to non-accredited laboratories.

Program Management

In an effort to continue the program under the current fee structure, HCFA has developed aggressive cost containment measures. For example, HCFA has developed the Alternate Quality Assessment Survey (AQAS). This is a self-evaluation developed to coincide with HCFA's onsite survey process which focuses on the laboratory's continuing quality improvement activities rather than the traditional survey. Laboratories that have had an initial onsite survey resulting in no deficiencies and satisfactory proficiency testing performance would receive an onsite survey on alternate 2-year cycles. Those laboratories not receiving an onsite survey would receive the AQAS form. The applicability of the AQAS includes physician office laboratories. Five percent of those laboratories receiving the AQAS would receive an onsite survey for validation purposes. The State agencies and HCFA regional offices will have discretion in adding or deleting laboratories eligible for the AQAS survey, but all State survey agencies will participate.

The CLIA program has evolved from the original projections of the scope and complexity of the program. HCFA, CDC, and the States have remained focused on the mission to improve the accuracy and reliability of tests administered in our Nation's laboratories, thereby improving health care for all and decreasing health care costs. HCFA and CDC have reevaluated the program, procedures, responsibilities, and timelines to continuously achieve more efficiencies. By maintaining flexibility and being result-oriented, the program has been successfully implemented as each of the agencies has responded to changing conditions.

HCFA continues to closely monitor the revenue and costs of CLIA. Adjustments to the fee structure, along with adjustments to the program, will be considered when and if the situation warrants.

Research, Demonstrations and Evaluation

Authorizing Legislation - Social Security Act, Sections 1110, 1115, 1875 and 1881(a); Social Security Amendments of 1967, Section 402; Social Security Amendments of 1972, Section 222.

Table III-12 Research and Demonstrations Summary Table

Program (Dollars in Thousands)	FY 1995 Appropriation	FY 1996 Policy 2/	FY 1997 Estimate	Increase or Decrease
Rural Health Care Transition Grants	\$17,584	\$10,000	---	- \$10,000
EACH/RPCH	2,000	---	---	---
Information, Counseling, &	10,036	4,500	4,500	- ---
Basic Research	45,146	40,000	50,810	+ 10,810
Total 1/	\$74,766	\$54,500	\$55,310	+ \$810

1/ Total excludes reimbursables.

2/ Based on levels of the ninth Continuing Resolution, including incremental policy adjustment. The FY 1996 Policy column will include amounts based on P. L. 104-99 dated January 26, 1996, which appropriates funds for DHHS programs through March 15, 1996.

BACKGROUND

HCFA's research program supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and our other customers and partners. Information from HCFA's research program is used by Congress, the Executive Branch and the States to improve the efficiency, quality, and effectiveness of the Medicare and Medicaid programs.

Accomplishments

HCFA's research, demonstrations and evaluation (RD&E) efforts have resulted in significant changes in the administration of HCFA programs, and have impacted substantially on program outlays, as well as the overall structure of the health care financing system.

For example, the prospective payment system and the physician fee schedule are both products of HCFA's research and demonstrations program. Assessments indicate that these reforms are achieving their goals of improving provider management and efficiency, without sacrificing the quality of care. As part of its current RD&E activities, HCFA and its contractors and grantees have:

- ▶ Developed and are testing an outcome-based quality assurance system for Medicare home health care, with expected implementation for ongoing programmatic use in FY 1998.
- ▶ Developed and are pilot testing outcome-based quality indicators for use in skilled nursing facilities (SNFs) with anticipated use in the revised SNF survey process. The new indicators and quality assurance system will provide HCFA with a greater ability to measure quality of care, thereby improving beneficiary health status.
- ▶ Pioneered methods of measuring access to care for vulnerable populations, producing numerous studies documenting potential access problems among vulnerable subgroups such as persons with AIDS, the disabled, low-income individuals and racial minorities.
- ▶ Conducted a demonstration which tested the feasibility and cost-effectiveness of a negotiated package price for coronary artery bypass graft surgery. The project resulted in:

Program Management

- lower overall program costs,
 - greater coordination of services to patients, and
 - reduced paperwork for beneficiaries.
- Provided leadership within the Nation's evolving health care system through the use of Statewide section 1115 waivers. Since January 1993, HCFA has approved 12 Medicaid demonstrations and 24 sub-state Medicaid demonstration projects affecting smaller parts of State Medicaid programs.

These waivers permit States to implement innovative, cost-effective managed care delivery systems, enabling States to expand coverage to uninsured populations. Additionally, HCFA meets its fiduciary responsibilities by requiring that a State's expenditures under the demonstration be no more than what they would have been without the demonstration. As a result of HCFA's guidance, flexibility and close work with the States, some 2.2 million persons, previously uninsured, now receive Medicaid coverage.

- Led the nation in developing risk adjustment mechanisms for payment systems, risk selection, and monitoring and evaluation purposes. Risk adjustment mechanisms help HCFA improve access to care, facilitate enrollment of beneficiaries into managed care, and better constrain the growth of program expenditures.
- Developed a package of information on the 1993 level of flu immunizations among the beneficiaries, as well as the level of mammography use among women in the Medicare program, both of which are being used nationally and regionally to promote these extremely important preventive services.

FY 1997 INITIATIVES

The FY 1997 estimate for funding HCFA's RD&E activity is \$55.3 million. HCFA's RD&E supports the mission and goals of its strategic plan through activities under the following four major research themes:

Monitoring and Evaluating Health System Performance

Effective management of HCFA's programs requires the development, design, and testing of new systems to monitor and evaluate the performance of the health care system. HCFA is conducting several major initiatives in this area.

- ▶ The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population intended to aid HCFA in monitoring and evaluating the Medicare program. It provides comprehensive and timely information on the Medicare populations' use of health care services and total reimbursements for those services distributed by sources of payment. HCFA is providing \$10.3 million in FY 1997 to support MCBS activities.
- ▶ Research and demonstration activities are underway to monitor and evaluate the impact of managed care on access to care, costs of services, and the quality of the care received.
- ▶ New projects are also underway to monitor and compare the health status and/or health risk behavior of beneficiaries in various delivery systems and how that behavior changes over time.

Improving Health Care Financing and Delivery Mechanisms

Growing costs in both the Medicare and Medicaid programs require the development of the next generation of financing and delivery systems to improve the efficiency and cost effectiveness of the health care system. At the same time, current research and demonstrations should continue to refine HCFA's existing payment mechanisms.

HCFA is conducting several demonstrations aimed at reducing costs and improving access:

- ▶ The Medicare Choices demonstration will evaluate the suitability of various types of new managed care delivery models, including point-of-service, open-ended HMOs, multiple option models, risk-adjusted models, primary care case management models, and preferred provider organizations. The demonstration supports HCFA's goal of providing a wider range of plan "choices" for the beneficiaries.
- ▶ Competitive bidding for clinical laboratory services and durable medical equipment. The evaluation will determine the effectiveness of competitive bidding as a payment mechanism for these two Medicare benefits.
- ▶ A competitive pricing demonstration to evaluate an array of cost-saving approaches to paying for managed care as an alternative to developing payment levels as a capitated percentage of the adjusted average per capita cost.
- ▶ A new demonstration, the Centers of Excellence, will replace the separate fee-for-service payments with capitated payments for the entire medical costs associated with certain expensive medical/surgical procedures such as knee and hip replacements.

Meeting the Needs of Vulnerable Populations

HCFA's research and demonstration projects continue to focus on ways of meeting the health care needs of its most vulnerable beneficiaries, including issues of access, delivery systems, and financing. Initiatives include:

- ▶ Developing innovative payment and delivery models to improve access to care in rural areas. A major emphasis is the implementation and evaluation of telemedicine demonstrations to assist HCFA in developing Medicare payment policies for teleconsultation.
- ▶ Studying the needs and services for special populations including those with end-stage renal disease (ESRD).
- ▶ Monitoring and evaluating State section 1115 demonstration activities, which provide States with increased flexibility, allowing them to expand Medicaid coverage to new populations while controlling Federal health care expenditures.

Improving Consumer Choice and Health Status

The utilization of HCFA data and other information to improve beneficiaries' ability to make more informed health care choices, both in the plans they select and in the services they utilize, is part of a long-term commitment to improve communication with the beneficiaries. Activities include research to:

- ▶ Help providers and beneficiaries assess medical treatment options;
- ▶ Assist beneficiaries in choice of health care plans;
- ▶ Provide information to improve beneficiaries' health status; and,

Program Management

- ▶ Continue to provide counseling and assistance services with special emphasis on outreach to minority and rural populations—information, counseling, and assistance grants (\$4.5 million).

Table III-13 Research and Demonstrations Funding Summary

Fiscal Year	Basic Research	Rural Health Care Transition	EACH/RPCH	ICA Grants	Rural Health Network Reform
1992	\$35,355	\$22,813	\$7,322	\$10,000	---
1993	35,579	22,679	---	9,920	---
1994	42,795	21,065	4,608	9,874	\$1,617
1995	45,001	17,500	2,000	10,036	---
1996	40,000	10,000	---	4,500	---

Table III-14 Congressional Mandates

(Dollars in Thousands)

Program	FY 1995	FY 1996	FY 1997
Basic Research	\$16,845	\$13,653	\$13,937
Rural Transition	17,500	10,000	---
EACH/RPCH	2,000	---	---
Information Counseling	10,036	4,500	4,500
Total, Congressional Mandates	\$46,381	\$28,153	\$18,437

HEALTH CARE FINANCING ADMINISTRATION

Table III-15 Research Obligations by Program Areas
FY 1995-1997

Program Areas	FY 1995	FY 1996	FY 1997
Rural Health Care Transition Grants	\$17,499,898	\$10,000,000	—
EACH/RPCH	2,000,000	---	---
Information, Counseling, and Assistance (ICA)	10,036,000	4,500,000	\$4,500,000
Subtotal	\$29,535,898	\$14,500,000	\$4,500,000
Basic Research Activity:			
Monitoring and Evaluating Health System Performance			
a. New	9,261,487	12,869,697	16,445,731
b. Continuations	2,379,459	625,000	2,660,000
	6,882,028	12,244,697	13,785,731
Improving Health Care Financing and Delivery Mechanisms			
a. New	21,225,541	11,296,077	16,284,456
b. Continuations	10,927,732	2,000,000	5,423,000
	10,297,809	9,296,077	10,861,456
Meeting the Needs of Vulnerable Populations			
a. New	12,971,688	10,834,226	15,542,126
b. Continuations	5,473,712	1,700,000	5,350,000
	7,497,976	9,134,226	10,192,126
Improving Consumer Choice and Health Status			
a. New	1,542,284	1,000,000	2,537,687
b. Continuations	1,099,685	900,000	2,100,000
	442,599	100,000	437,687
Market Research on Consumer Information Needs			
a. New	—	4,000,000	—
b. Continuations	—	4,000,000	—
	—	---	---
Basic Research Activity			
a. New	19,880,588	9,225,000	15,533,000
b. Continuations	25,120,412	30,775,000	35,277,000
Subtotal Basic Research Activity	\$45,001,000	\$40,000,000	\$50,810,000
Total Research, Demonstrations and Evaluation Obligations	\$74,536,898	\$54,500,000	\$55,310,000

*Program Management***Administrative Costs**

Authorizing Legislation - Reorganization Act of 1953.

Table III-16 Administrative Costs Summary Table¹

	FY 1995 Appropriation	FY 1996 Policy	FY 1997 Estimate	Increase or Decrease
Federal Administration	\$353,494,000	\$327,894,000	\$336,106,000	+\$8,212,000
Medicare Handbook	---	---	\$20,000,000	+\$20,000,000
HCFA On-Line	---	---	\$2,000,000	+\$2,000,000
Long-Term Care	---	---	\$1,000,000	+\$1,000,000
Total Obligations	\$353,494,000	\$327,894,000	\$359,106,000	+\$31,212,000
Full-time Equivalents	4,129	4,100	4,100	---

BACKGROUND

The Medicare and Medicaid programs ensure the health care security of 72 million beneficiaries. The Administrative Costs budget provides funds for the staff and operations of HCFA to administer these programs. Compared to the over \$300 billion required to continue Medicare and Medicaid benefits in FY 1997, the Administrative Costs budget represents only one tenth of one percent (0.1%) of total program costs. Although slight in proportion to total program spending, these administrative costs are integral to the operation of Medicare and Medicaid.

¹

Based on levels of the ninth CR, the "FY 1996 Policy" column will include amounts based on P.L. 104-99, dated January 26, 1996 which appropriates funds for DHHS programs through March 15, 1996.

HEALTH CARE FINANCING ADMINISTRATION

Funding for Administrative Costs allows 4,100 HCFA employees to execute the government's responsibilities in continuing Medicare and Medicaid services. These responsibilities include providing direct program services to beneficiaries, providers, Medicare contractors, State agencies, as well as the general public. In addition, these responsibilities include combating fraud, waste, and abuse; overseeing safety and quality of health care; promoting managed care; responding to data requests and implementing legislation; and developing efficient payment and operating systems. Since HCFA's Administrative Costs are primarily driven by program benefit workloads, significant changes in this funding level directly affects the level of HCFA services.

RATIONALE FOR THE BUDGET REQUEST**Medicare**

HCFA employees are responsible for carrying out the limited but essential Federal role in administering the Medicare program serving an estimated 39 million beneficiaries. To accomplish this task, we work with:

- ▶ 786,000 physicians and other practitioners;
- ▶ 40,000 State Agency employees;
- ▶ 1,600 employees of Peer Review Organizations; and,
- ▶ 22,000 private insurance company employees that process Medicare claims.

HCFA has fundamental responsibilities to fight fraud, waste, and abuse in the Medicare program, ensure the quality of care provided to beneficiaries, and continue to improve Medicare program operations. Among the most crucial functions HCFA employees perform every day are:

Claims Payment (509 FTEs, \$44.6 Million)

Processing claims for Medicare health insurance benefits is fundamental to the operation of the Medicare program. HCFA employees are ultimately responsible for ensuring that payments are made, through Medicare contractors, for medically appropriate and covered services. HCFA also ensures that these services are provided to eligible beneficiaries by qualified providers. Payments will be made for over 861 million Medicare claims in FY 1997. This massive claims volume reinforces the importance of HCFA's continuous reevaluation of efficient operational policies and practices to ensure Medicare claims are processed in an accurate, and consistent manner. The following are examples of the important daily duties HCFA employees perform:

- ▶ HCFA develops price indices and wage guidelines to ensure that changes in Medicare program payments are consistent with the economic experience of providers and prevailing market conditions.
- ▶ HCFA calculates payments for managed care plans, and transfers funds to managed care plans.
- ▶ HCFA works to perfect electronic media claims processing by developing measures to test format standards.
- ▶ HCFA ensures the proper design and development of HCFA's Medicare Transaction System (MTS). MTS will allow Medicare contractors to process claims through a single unified processing system.
- ▶ HCFA works to ensure our current databases are coordinated and restructured to allow full integration with MTS beginning in FY 1997. This effort also requires us to establish telecommunications links with MTS and a segregated MTS test facility at our data center.

HEALTH CARE FINANCING ADMINISTRATION

- ▶ HCFA facilitates the transition of Medicare contractors to function in the MTS environment. HCFA also ensures that these transitions do not cause any adverse effects on beneficiaries and providers.
- ▶ HCFA ensures that facilities performing heart, lung, and liver transplants qualify under Medicare provisions before making payments for these procedures.
- ▶ HCFA processes Medicare claims for 12 demonstration projects with payments estimated at \$150 million annually under our research, demonstration and evaluation program.

Beneficiary Services (583 FTEs, \$51.1 Million)

For HCFA, customer service is an attitude reflecting a strong commitment to excellence. HCFA recognizes the importance of involving beneficiaries in defining their health care needs. Informed beneficiaries and customers will make better treatment choices and improve HCFA's ability to respond to customer needs. HCFA employees continuously interact with beneficiaries, providing them with current information on programs, services, and health care choices such as managed care. HCFA also continuously solicits feedback from beneficiaries on such issues as quality of care and special program initiatives. In addition, HCFA employees continue efforts to improve communication and data sharing with beneficiaries and customers. The following are some examples of HCFA beneficiary service activities:

- ▶ Through HCFA On-Line, HCFA plans to systematically reshape all of our communications efforts to improve our interaction with beneficiaries, partners, and customers. Initial work on HCFA On-Line has refined the scope and schedule of many HCFA communication activities, as well as clarified the allocation of resources necessary to implement these activities. Major areas of work during FY 1997 are as follows:

- **Market Research**—HCFA is completing the first phase of a three part inquiry of beneficiaries, providers, and other partners and customers to better understand their information needs. Inventories of existing beneficiary satisfaction indicators, focus groups, and surveys are underway, and provider and partner surveys are scheduled for FY 1997. The results of the market research will define the remainder of HCFA On-Line activities, and allow the agency to adjust and/or re-direct resource allocations.
 - **Provider and Beneficiary Outreach**—HCFA is concluding an analysis, assessment of technology requirements, and planning for a HCFA "800" number telephone system to potentially serve as the single customer service inquiry hotline for beneficiaries.
 - **Electronic Information Support**—HCFA will begin work on restructuring current databases to allow more effective and efficient use and access to HCFA data. Improved information dissemination via the Internet and client server technology will assist beneficiaries in making health care choices, and assist other customers such as researchers and health care policy experts.
- ▶ HCFA will print and distribute an updated version of the Medicare handbook to every beneficiary in FY 1997.
 - ▶ In FY 1997, HCFA expects to respond to over 1,800 Freedom of Information Act (FOIA) initial requests and appeals. In addition, it is estimated that HCFA will respond to another 40,000 non-FOIA requests through central office, regional offices and contractors, 2,100 queries from the media, and 600,000 phone calls through our hotline.

HEALTH CARE FINANCING ADMINISTRATION

- ▶ HCFA conducts workshops for rural health providers on latest developments in Medicare managed care, and conveys to providers suggestions for creating integrated service delivery networks in rural areas.
- ▶ HCFA educates beneficiaries enrolled in both fee-for-service and managed care options. This is accomplished by conducting beneficiary needs assessments and activities through the use of surveys, demonstration and pilot projects, focus groups, and radio talk shows.
- ▶ HCFA constantly strives to improve communications with beneficiaries. Examples include development of a Medicare Summary Notice, and development of a single point of contact for beneficiaries with a Medicare inquiry. By interacting with the Medicare Transaction System, the single point of contact will be able to answer all beneficiary questions on entitlement, eligibility, payment decisions, and claims status.
- ▶ To improve further the ability to disseminate information to beneficiaries and customers, HCFA is working to develop outreach programs that use new technology. For example, HCFA is: utilizing the Internet and other communication vehicles; collecting information on quality of care and health status of beneficiaries; and working with an on-line imaging system to expedite responses to the growing volume of correspondence with our customers.
- ▶ HCFA performs Medicare and Medicaid beneficiary casework, and provides policy guidance to customers. HCFA expects to handle over 3,000 cases in FY 1997.
- ▶ HCFA is responsible for direct billing beneficiaries and third parties (i.e., State agencies and private groups) for Medicare premiums, soliciting beneficiary enrollment during general enrollment periods when they may

Program Management

enter the Medicare program, and preparing Medicare cards for beneficiaries.

- ▶ HCFA maintains enrollment data on every Medicare beneficiary. Because beneficiary health care data is confidential and of a personal nature, ensuring the privacy and security of these data is critical.
- ▶ HCFA plans, directs, and coordinates the production of audio and film products including public service announcements and informational films. HCFA also prepares and publishes general purpose publications, including *Medicare and Managed Care Plans*, and other publications.

Quality Assurance (852 FTEs, \$74.6 Million)

Protecting beneficiaries by ensuring high quality health care is a priority for HCFA employees. HCFA's emphasis on protecting the health and safety of beneficiaries is evidenced by our thorough oversight of Medicare providers. The following are some examples of the important duties HCFA employees perform:

- ▶ Working with State agencies, HCFA surveys hospitals, home health agencies, nursing homes, hospices, dialysis centers, and other providers to ensure the health and safety of our beneficiaries. In FY 1997, HCFA will conduct recertification surveys of over 26,000 health care providers.
- ▶ Through HCFA's Long-Term Care initiative, we are working to create and develop alternative long-term care delivery models so that these services are more cohesive and responsive to beneficiary needs.
- ▶ HCFA administers the Clinical Laboratory Improvement Amendments (CLIA) of 1988, which ensure the quality of laboratories performing medical tests for beneficiaries. With more than 152,000 laboratories

HEALTH CARE FINANCING ADMINISTRATION

nationwide covered by CLIA, HCFA estimates that 40,000 will be inspected in FY 1997 and FY 1998.

- ▶ HCFA is working to promote enhanced quality and accountability in the survey and certification program by revising the conditions of participation for hospitals, home health agencies, and end-stage renal disease facilities. HCFA is emphasizing the provider's responsibility to monitor health outcomes, ensure high quality care, and apply more effective internal quality management.
- ▶ For all of its survey processes, HCFA will continue efforts to develop quality indicators that will allow health and safety standards to focus heavily on patient outcomes rather than on a provider's "paperwork" compliance. This effort will promote efficiencies for health care facilities, and assure the most effective health care for beneficiaries.
- ▶ HCFA educates providers and surveyors on topics such as restraint use in nursing homes, cytogenetic testing, infection control, quality of life issues, and dialysis.
- ▶ HCFA is continuing certification efforts of non-accredited hospitals with a major focus on investigations of patient dumping, which is prohibited by section 1867 of the Social Security Act. These efforts are vital as the number of dumping allegations continues to rise. Patient dumping occurs when a hospital refuses to treat or chooses to transfer patients before administering appropriate medical screening examinations within the capability of the hospital's emergency department.
- ▶ HCFA works closely with Peer Review Organizations (PROs) to provide guidance to health care providers in order to improve the quality of care given to beneficiaries. In addition, HCFA creates and provides to the PROs the data files necessary for these quality-of-care analyses.

Program Management

- ▶ HCFA conducts followup studies to measure progress in diagnosis/prognosis of pneumonia in selected Medicare beneficiaries. We also conduct pilot tests designed to increase pneumococcal and flu vaccinations, and mammography screenings among underserved minority groups.
- ▶ By conducting regional quality improvement projects, HCFA works to reduce the spread of antibiotic resistant infection.
- ▶ HCFA strives for the best care for beneficiaries by developing quality assurance, as well as quality performance standards in managed care plans.
- ▶ HCFA provides health information to Federal and private health care researchers who conduct medical treatment effectiveness studies. Also, as more beneficiaries enroll in managed care, HCFA needs to increase efforts to collect managed care encounter data necessary to evaluate the quality and cost of care provided to these beneficiaries.

Program Integrity and Management (1,240 FTEs, \$108.6 Million)

HCFA is committed to prudent management of America's limited tax dollars. HCFA takes its fiscal stewardship responsibility seriously. We work aggressively to combat and prevent Medicare fraud, identify inappropriate payments and recoup overpayments, while continuously improving our program oversight activities. The following are some examples of the program integrity activities performed by HCFA employees:

- ▶ Through HCFA's Operation Restore Trust (ORT) anti-fraud demonstration, we work in partnership with the Office of Inspector General and the Administration on Aging to aggressively identify fraud,

HEALTH CARE FINANCING ADMINISTRATION

waste and abuse associated with home health, nursing homes, durable medical equipment supplies, and hospices.

- ▶ HCFA utilizes fraud and abuse data systems to facilitate investigation of program data, and to initiate payment recovery actions on a national scale.
- ▶ HCFA prepares cost estimates for legislative proposals such as omnibus budget reconciliation acts that impact the Medicare and Medicaid programs.
- ▶ HCFA develops the Medicare Part B premium; inpatient hospital deductible; the Medicare Part A premium rate for voluntary enrollees; and the physicians' Medicare volume performance standard and conversion factor.
- ▶ HCFA develops the payment rates for the annual update of the adjusted average per capita cost rate-book. This essential rate-book is used to pay managed care organizations that enter into risk contracts with HCFA.
- ▶ HCFA examines new and existing health care technologies to determine if payments for technology changes are appropriate.
- ▶ HCFA establishes payment rates annually for hospitals, physicians, independent labs, ambulatory service centers, durable medical equipment (DME), and end-stage renal disease (ESRD) facilities.
- ▶ In HCFA's research, demonstrations, and evaluation program we manage over 800 contracts, cooperative agreements, and grants totaling \$55.3 million in FY 1997, as well as intramural studies and analysis. For example, HCFA conducts major research studies and demonstrations

designed to improve payment methodologies in managed care, and improve risk adjustment mechanisms.

- ▶ Utilizing the expertise of Los Alamos National Laboratories (LANL), HCFA works to incorporate sophisticated analytical and statistical techniques to bolster our Medicare fraud and abuse detection capability. This fraud and abuse detection capability is an integral part of the Medicare Transaction System (MTS) design.
- ▶ HCFA performs post-pay reviews of all types of Medicare services. For example, we perform post-pay reviews of ambulance companies to identify overpayments and identify inappropriate utilization. These reviews have already revealed ambulance overpayments in excess of \$109 million.
- ▶ HCFA conducts surveys of a sample of targeted physician-owned labs to identify areas of billing abuse. We identify abusive and potentially fraudulent billing practices by portable x-ray suppliers for services rendered in nursing homes. Also, HCFA directs reviews of Medicare Part B payments for durable medical equipment and other services.
- ▶ HCFA is responsible for maintaining a series of data systems containing vital files used by Medicare contractors in pursuing recoveries for court-directed Medicare Secondary Payer settlements. HCFA also maintains data systems needed to formulate current pricing schemes, fee schedules, and alternative payment models for all Medicare services.
- ▶ HCFA develops and implements Medicare coverage, payment, and provider enrollment requirements, and oversees compliance with these requirements.

HEALTH CARE FINANCING ADMINISTRATION

- ▶ HCFA actively seeks public input to ensure all Medicare policies are fair, equitable, and effective.

Medicaid

HCFA employees serve a pivotal oversight role in monitoring the planning, development, and implementation of Medicaid program operations in our regional offices and State Medicaid agencies. HCFA employees operate through a series of flexible partnerships with States with emphasis on providing States with technical assistance in implementing State program waivers. For example, we work closely with the National Governors' Association and the State Medicaid Directors' Association to streamline the process for waiver approval.

Also, HCFA employees administer the State Medicaid grants process to provide for administrative and program payments to States, including budget preparation by States. HCFA employees encourage improvement, innovation, and quality in the Medicaid program every working day through many important activities, including:

Program Payments to States (216 FTEs, \$18.9 Million)

Although States have considerable flexibility in establishing their Medicaid programs, HCFA provides the grants to States for Medicaid. In FY 1997, HCFA will provide \$102.3 billion in matching funds to the States for Medicaid. In addition to administering the State grants process, HCFA employees provide assistance to States in several other ways including developing, operating, and managing a program for evaluating the performance of Medicaid State agencies and fiscal agents. The following are some examples of the important daily duties HCFA employees perform:

Program Management

- ▶ HCFA makes Medicaid payments to States, accurately and on time.
- ▶ HCFA provides cost estimates for the Medicaid program, including estimates for proposed changes to Medicaid.
- ▶ To determine Medicaid funding requirements, HCFA maintains and enhances an automated State Medicaid Budget Expenditure System, and provides States with a shared data collection system.
- ▶ Working with State Medicaid agencies, HCFA performs data match projects to identify duplicate claims and payment for skilled nursing facilities and durable medical equipment services.
- ▶ HCFA detects and solves payment problems arising from individuals eligible for both Medicare and Medicaid benefits, particularly when beneficiaries are enrolled in both fee-for-service and managed care programs. These payment problems will become more frequent as States enroll more beneficiaries in managed care.
- ▶ HCFA calculates Medicaid drug rebate amounts and distributes these data to State Medicaid agencies. We also respond to Medicaid payment data requests from State agencies, the Congress, researchers, and other private and public entities.

Beneficiary Services (133 FTEs, \$11.6 Million)

HCFA employees work with States to ensure Medicaid beneficiaries are informed of their available health care options and benefits. These efforts are essential to the efficient and cost-effective utilization of Medicaid resources. Moreover, as more beneficiaries move into Medicaid managed care plans, HCFA continues to assist States with managed care enrollment, marketing, contract management, and other activities to ensure plans are serving beneficiaries

HEALTH CARE FINANCING ADMINISTRATION

properly. The following are some examples of HCFA's beneficiary service activities:

- ▶ HCFA provides materials to educate beneficiaries about available health care choices in Medicaid managed care.
- ▶ HCFA develops Medicaid beneficiary and provider outreach programs. For example, we are working to ensure that vulnerable populations, such as HIV/AIDS infected individuals, are aware of their health care choices.
- ▶ HCFA is a focal point for answering beneficiary questions, resolving Medicaid problems, and referring beneficiaries to appropriate State partners.
- ▶ HCFA identifies and provides information to Medicare beneficiaries who may be eligible for the Qualified Medicare Beneficiary (QMB) benefit—a program in which the Medicare co-payments and deductibles incurred by eligible beneficiaries are paid by Medicaid.
- ▶ HCFA actively seeks and encourages beneficiary input as we develop Medicaid policy.
- ▶ HCFA works with the Indian Health Service to improve the health of American Indians and Alaska natives.

Quality Assurance (178 FTEs, \$15.6 Million)

HCFA is actively involved in promoting high quality health care for beneficiaries. HCFA employees perform several activities ranging from monitoring Medicaid program performance to coordinating Medicaid health quality activities with the Public Health Service and other national organizations. In addition, HCFA employees continuously work to educate and strengthen the

Program Management

ability of State agency partners to improve the quality of care and quality of life for beneficiaries. The following are some examples of HCFA's quality assurance activities:

- ▶ HCFA collects Medicaid data on beneficiaries, and data on quality standards to assess the impact of current Medicaid policies. We also collect Medicaid data for use in developing program improvements.
- ▶ In partnership with the National Committee for Quality Assurance, HCFA is developing a new performance measurement system aimed at improving quality in managed care organizations that serve Medicaid beneficiaries.
- ▶ HCFA employees monitor home and community-based services waivers, and evaluate the quality of Medicaid community-based long-term care.
- ▶ In conjunction with the Centers for Disease Control, HCFA is making available to States and providers current information on immunization practices.
- ▶ HCFA assists States in developing and implementing quality assurance programs for adult foster homes. In addition, we continue to monitor beneficiary access to care in Medicaid, and strive for outcome-oriented quality assurance.
- ▶ Working with private and public sector managed care purchasers and consumers through the Foundation for Accountability, HCFA is participating in the development of the next generation of outcome measures for managed care.

Partnership with States (389 FTEs, \$34.1 Million)

HCFA works in partnership with States on Medicaid eligibility, coverage, and payment activities. HCFA's partnership role is increasingly evident in the State Medicaid section 1915(b) and section 1115 Medicaid waiver process. Also, HCFA provides technical assistance to States and other interested groups on all special Medicaid initiatives. The following are some examples of HCFA's important partnership activities:

- ▶ HCFA promotes flexibility by helping States develop their sections 1915(b) and 1115 Medicaid waivers. These waivers permit States to implement managed care delivery systems and expand Medicaid eligibility to uninsured populations. An estimated 1.6 million beneficiaries are receiving services through these waivers.
- ▶ HCFA continues proactive efforts to assist States with their Medicaid waivers. Since 1993, we have worked with 12 States to approve and monitor Medicaid waivers for welfare demonstrations. In addition, Medicaid waivers are pending in 8 additional States. These waivers enable States to continue providing essential health care services while encouraging independence from welfare.
- ▶ HCFA provides actuarial and economic expertise on the Medicaid program to other government agencies.
- ▶ In partnership with States and drug manufacturers, HCFA works to improve drug rebate program operations.
- ▶ HCFA assists States in developing programs to better meet the beneficiaries' needs for home and community-based services, as well as to meet the needs for child health, maternal health, beneficiaries with disabilities, and services for other vulnerable population groups.

Program Management

- ▶ HCFA's partnership with States is instrumental in improving relationships between Medicaid agencies and State Medicaid fraud control units.
- ▶ HCFA works with States to develop acceptable State Plan Amendments to the Medicaid program.
- ▶ HCFA provides detailed Medicaid eligibility and claims data to support Medicaid research by State agencies, Federal agencies, and private industry.
- ▶ HCFA works with States to preserve State flexibility in developing and interpreting Medicaid eligibility requirements.

In conclusion, making sure the Medicare and Medicaid programs work is HCFA's job. Far from being a centralized bureaucracy, HCFA represents government at its best. With only a small workforce, we work hand-in-hand with hundreds of thousands of private industry and State employees, health care providers, and PROs staff to ensure that 72 million aged, disabled, and low income beneficiaries have access to the best possible health care when they need it.

HEALTH CARE FINANCING ADMINISTRATION

Funding for HCFA's Administrative Costs program during the last five years has been as follows:

Table III-17 Federal Administration Funding Summary

Fiscal Year	Funding Level	FTE Ceiling
1992	\$331,145,000	4,272
1993	\$330,718,000	4,236
1994	\$346,836,000	4,186
1995	\$353,494,000	4,129
1996	\$327,894,000	4,100

Section IV Contents

SUPPORTING TABLES

HMO LOAN AND LOAN GUARANTEE FUND

Appropriation Language	IV-37
Language Analysis	IV-38
General Statement	IV-39

SUPPORTING MATERIAL

Proposed Legislation Summary	IV-41
Significant Items	IV-42

Section IV List of Tables

SUPPORTING TABLES

GRANTS TO STATES FOR MEDICAID

Table IV-1	Summary of Changes	IV-1
Table IV-2	Authorizing Legislation	IV-2
Table IV-3	Appropriations History Table	IV-3
Table IV-4	Medicaid Requirements	IV-4
Table IV-5	Budget Authority by Object	IV-5
Table IV-6	Amounts Available for Obligation	IV-6
Table IV-7	Unadjusted State Estimates	IV-7
Table IV-8	Estimates of Grant Awards	IV-8

HEALTH CARE FINANCING ADMINISTRATION

PAYMENTS TO HEALTH CARE TRUST FUNDS

Table IV-9	Budget Authority by Object	IV-10
Table IV-10	Authorizing Legislation	IV-11
Table IV-11	Appropriations History Table	IV-12
Table IV-12	Funding Levels for Budget Activities	IV-13
Table IV-13	SMI Premium Estimates	IV-14

PROGRAM MANAGEMENT

Table IV-14	Amounts Available for Obligation	IV-15
Table IV-15	Summary of Changes	IV-16
Table IV-16	Budget Authority by Activity	IV-17
Table IV-17	Authorizing Legislation	IV-18
Table IV-18	Appropriation History Table	IV-19
Table IV-19	Account Summary	IV-20
Table IV-20	Budget Authority by Object - 2 Year	IV-21
Table IV-21	Budget Authority by Object (CLIA)	IV-23
Table IV-22	Budget Authority by Object - 3 Year	IV-25
Table IV-23	Budget Authority (Administration)	IV-27
Table IV-24	Detail of FTE Employment	IV-28
Table IV-25	HCFA's FTE Ceiling	IV-29
Table IV-26	Detail of Positions	IV-30
Table IV-27	Change of Configuration (Contractors)	IV-31
Table IV-28	State Listing of Intermediaries (Contractors)	IV-32
Table IV-29	Voluntary and Involuntary Terminations (S&C)	IV-35
Table IV-30	Medicare Managed Care	IV-36

HMO LOAN AND LOAN GUARANTEE FUND

Table IV-31	Amounts Available for Obligation	IV-40
-------------	--	-------

*Supporting Tables***GRANTS TO STATES FOR MEDICAID****Table IV-1 Summary of Changes**

1996 Budget authority	\$83,252,217,000
1997 Estimated budget authority	<u>\$101,192,815,000</u>
Net Change	\$17,940,598,000

Explanation of Changes

	1996 Current Estimate Base Budget Authority	Change From Base Budget Authority
Program Increases:		
1. Medical Assistance Payments State Estimates	\$90,852,362,000	\$7,209,615,000
2. Unobligated balance, start of year	(12,740,491,000)	11,639,397,000
3. Vaccine Purchase	<u>212,981,000</u>	<u>256,028,000</u>
Total program increases	\$78,324,852,000	\$19,105,040,000
Program Decreases:		
1. State Administration State Estimates	\$4,198,271,000	(\$26,348,000)
2. Unobligated balance, end of year	1,101,094,000	(1,101,094,000)
3. Medicaid Initiatives	<u>(372,000,000)</u>	<u>(37,000,000)</u>
Total program decreases	\$4,927,365,000	(\$1,164,442,000)
TOTAL	\$83,252,217,000	\$17,940,598,000

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID**Table IV-2** Authorizing Legislation

	1996 Amount Authorized	1996 Policy	1997 Amount Authorized	1997 Budget Estimate
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	<u>\$83,252,217,000</u>	Indefinite	<u>\$101,192,815,000</u>
Total appropriations	1/	\$83,252,217,000	2/	\$101,192,815,000

1/ This authorization of \$83,252,217,000 is also cited for the Vaccines For Children Program.
The total requested against this authorization is \$212,981,000.

2/ This authorization of \$101,192,815,000 is also cited for the Vaccines For Children Program.
The total requested against this authorization is \$469,009,000.

*Supporting Tables***GRANTS TO STATES FOR MEDICAID****Table IV-3 Appropriations History Table**

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1988	28,120,000,000	30,046,000,000	30,046,000,000	30,768,496,807 ^{1/}
1989	32,732,589,000	32,739,589,000	34,236,000,000	34,857,674,120 ^{2/}
1990	37,398,197,000	38,616,497,000	39,136,654,000	40,690,085,460 ^{3/}
1991	44,901,509,000	45,014,966,000	47,281,301,000	53,393,353,752 ^{4/}
1992	59,807,649,000	59,899,149,000	59,899,149,000	69,765,840,968 ^{5/}
1993	84,401,234,000	84,411,234,000	82,605,650,000	82,595,650,000
1994	89,060,413,000	89,077,413,000	89,077,413,000	89,077,413,000
1995	89,237,775,000	89,237,775,000	89,240,775,000	89,240,775,000
1996	82,142,072,000	82,142,072,000	^{6/}	83,252,217,000 ^{7/}
1997	101,192,815,000			

1/ Includes \$722.5 ml under indefinite authority.

2/ Includes \$621.7 ml under indefinite authority.

3/ Includes \$1553.4 ml under indefinite authority.

4/ Includes \$6027.0 ml under indefinite authority.

5/ Includes \$9886.7 ml under indefinite authority.

6/ There was no Senate allowance in FY 1996.

7/ This amount is based on the Seventh FY 1996 Continuing Resolution (P.L. 104-91).

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID**Table IV-4 Medicaid Requirements**

	1996 Policy	1997 Estimate
November '95 State Estimates (MAP & ADM)	\$94,817,633,000	\$101,988,800,000
State Certification	154,000,000	163,100,000
Fraud Control Units	79,000,000	82,000,000
Total, unadjusted estimates	\$95,050,633,000	\$102,233,900,000
<u>Adjustments</u>		
Medicaid Initiative: Medicaid Financial Management Reviews	(372,000,000)	(409,000,000)
Vaccines For Children Program	212,981,000	469,009,000
Subtotal, adjustments	(\$159,019,000)	60,009,000
Current law requirement	\$94,891,614,000	\$102,293,909,000
Unobligated Balances, Start of year	(12,740,491,000)	(1,101,094,000)
End of year	1,101,094,000	0
Appropriation/budget authority	\$83,252,217,000	\$101,192,815,000

*Supporting Tables***GRANTS TO STATES FOR MEDICAID****Table IV-5 Budget Authority by Object**

	1996 Policy	1997 Estimate	Increase or Decrease
Grants, Subsidies and Contributions	\$83,252,217,000	\$101,192,815,000	\$17,940,598,000
Total budget authority	\$83,252,217,000	\$101,192,815,000	\$17,940,598,000

HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Appropriation

Grants to States for Medicaid

Table IV-6 Amounts Available for Obligation

	1995 Actual	1996 Policy	1997 Estimate
Appropriation: Annual	\$89,240,775,000	\$83,252,217,000	\$101,192,815,000
Unobligated balance, start of year	13,032,713,000	12,740,491,000	1,101,094,000
Unobligated balance, end of year	(12,740,491,000)	(1,101,094,000)	0
Total obligations	\$89,532,997,000	\$94,891,614,000	\$102,293,909,000

Supporting Tables

MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE CATEGORY

Table IV-7 Unadjusted State Estimates

(Dollars in thousands)

	FY 1996		FY 1997	
	Amount	%	Amount	%
Nursing Facility	\$17,956,000	19.64%	\$19,700,000	19.94%
Inpatient Hosp - Reg Pmnts	15,623,000	17.09%	16,711,000	16.91%
Inpatient DSH Adj Payment	7,532,000	8.24%	7,801,000	7.89%
Prescribed Drugs	6,331,000	6.93%	6,752,000	6.83%
Physician	4,672,000	5.11%	4,842,000	4.90%
Ins. Payments - Other	5,324,000	5.82%	6,304,000	6.38%
Outpatient Hospital	4,083,000	4.47%	4,174,000	4.22%
ICF/MR Public	3,688,000	4.03%	3,900,000	3.95%
All Other	3,804,000	4.16%	4,117,000	4.17%
Home and Commun. Waivers	3,350,000	3.67%	3,591,000	3.63%
Mental Health DSH Adj.	2,238,000	2.45%	2,250,000	2.28%
ICF/MR Private	2,157,000	2.36%	2,263,000	2.29%
Clinic	1,947,000	2.13%	2,136,000	2.16%
Personal Care	2,049,000	2.24%	2,212,000	2.24%
Mental Health Pmnts	1,766,000	1.93%	1,879,000	1.90%
Ins Pmnts - Pt B Prms	1,680,000	1.84%	1,898,000	1.92%
Ins Pmnts - Group Health	2,186,000	2.39%	2,897,000	2.93%
Home Health	1,112,000	1.22%	1,197,000	1.21%
Dental	897,000	0.98%	936,000	0.95%
Other Practitioners	525,000	0.57%	556,000	0.56%
Targeted Case Management	833,000	0.91%	882,000	0.89%
Ins Pmnts - Pt A Prms	603,000	0.66%	693,000	0.70%
EPSDT Screening Services	531,000	0.58%	559,000	0.57%
Lab & Radiological	469,000	0.51%	492,000	0.50%
Ins Pmnts - Coins. & Deduct.	321,000	0.35%	340,000	0.34%
Federal Qualified Health Ctr	277,000	0.30%	292,000	0.30%
Rural Health Clinics	180,000	0.20%	193,000	0.20%
Sterilizations	163,000	0.18%	167,000	0.17%
Hospice	175,000	0.19%	211,000	0.21%
H&C Care Disabled Elderly	14,000	0.02%	14,000	0.01%
Community Supported Living	14,000	0.02%	13,000	0.01%
Abortions	0	0.00%	0	0.00%
Drug Rebate Offset	(1,096,000)	-1.20%	(1,158,000)	-1.17%
Subtotal	\$91,404,000	100.00%	\$98,814,000	100.00%
Collections/Adjustments	(552,000)		(752,000)	
Total	\$90,852,000		\$98,062,000	

HEALTH CARE FINANCING ADMINISTRATION

STATE TABLES

Table IV-8 Estimates of Grant Awards
(Dollars in thousands)

	FY 95 Obligations	FY 96 Policy	FY 97 Estimate
Alabama	\$1,400,065	\$1,416,484	\$1,520,446
Alaska	171,034	197,091	204,680
American Samoa	2,240	2,350	2,350
Arizona	1,171,573	1,332,520	1,325,846
Arkansas	879,452	954,085	998,331
California	8,782,541	9,461,232	9,867,861
Colorado	810,581	735,950	814,246
Connecticut	1,286,615	1,367,894	1,416,670
Delaware	178,783	218,467	226,930
Dist. of Columbia	447,294	477,861	477,861
Florida	3,515,058	3,833,340	4,245,586
Georgia	2,257,052	2,410,144	2,560,774
Guam	3,870	4,060	4,060
Hawaii	346,715	349,771	353,906
Idaho	239,683	287,250	301,650
Illinois	3,336,519	3,406,591	3,573,634
Indiana	1,282,595	1,896,055	1,861,908
Iowa	741,575	832,861	894,115
Kansas	585,599	604,710	620,406
Kentucky	1,497,396	1,645,896	1,782,113
Louisiana	3,095,218	2,365,605	2,424,629
Maine	604,281	645,599	698,630
Maryland	1,311,387	1,438,126	1,561,861
Massachusetts	2,287,805	2,558,769	2,675,078
Mass. (Blind)	43,429	48,496	52,496
Michigan	3,034,158	3,285,208	3,418,303
Minnesota	1,585,151	1,641,356	1,760,484
Mississippi	1,234,078	1,293,728	1,399,034
Missouri	1,691,384	1,809,615	1,929,849
Montana	245,577	262,718	271,025
Nebraska	\$390,295	\$448,421	\$484,300
Nevada	224,681	275,849	305,624
New Hampshire	387,937	366,172	372,967
New Jersey	2,622,422	2,880,657	3,079,285
New Mexico	594,496	648,102	703,721

Supporting Tables

STATE TABLES

Table IV-8 Estimates of Grant Awards (cont.)
(Dollards in thousands)

	FY 95 Obligations	FY 96 Policy	FY 97 Estimate
New York	12,038,189	13,208,854	15,585,510
North Carolina	2,533,911	2,838,682	3,226,426
North Dakota	205,903	224,174	229,756
N. Mariana Islands	1,160	1,220	1,220
Ohio	3,752,602	4,029,913	4,478,468
Oklahoma	843,454	902,557	911,934
Oregon	941,233	988,946	1,036,489
Pennsylvania	4,078,269	4,310,672	4,525,449
Puerto Rico	122,200	128,100	128,100
Rhode Island	588,348	463,600	472,574
South Carolina	1,501,645	1,516,262	1,501,889
South Dakota	229,946	242,059	252,775
Tennessee	2,104,031	2,330,988	2,444,968
Texas	5,813,410	6,061,377	6,581,593
Utah	415,356	468,069	488,555
Vermont	220,573	235,040	247,318
Virginia	1,046,168	1,186,273	1,242,299
Virgin Islands	4,029	4,220	4,220
Washington	1,591,656	1,590,725	1,653,050
West Virginia	933,879	1,028,227	1,065,001
Wisconsin	1,422,359	1,542,780	1,604,580
Wyoming	114,441	111,862	115,967
Subtotal	\$88,791,301	\$94,817,633	\$101,988,800
Survey & Certification	137,317	154,000	163,100
Fraud Control Units	63,178	79,000	82,000
Vaccines For Children	420,255	212,981	469,009
Adjustments	120,946	-372,000	-409,000
Total Obligations	\$89,532,997	\$94,891,614	\$102,293,909

HEALTH CARE FINANCING ADMINISTRATION

PAYMENTS TO HEALTH CARE TRUST FUNDS

Table IV-9 Budget Authority by Object

	1996 <u>Appropriation</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Grants, Subsidies, and Contributions	\$61,331,000,000 ^{1/}	\$59,456,000,000	(\$1,875,000,000)
Insurance claims and indemnities	419,000,000	481,000,000	62,000,000
Other Services	<u>149,000,000</u>	<u>142,000,000</u>	<u>(7,000,000)</u>
Budget Authority	\$61,899,000,000	\$60,079,000,000	(\$1,820,000,000)

1/ This amount includes \$6,966,662,000 to repay (with interest) the SMI Trust Fund which was drawn down in FY 1995 to cover a shortfall in the appropriation for the Federal match of Part B premiums.

*Supporting Tables***PAYMENTS TO HEALTH CARE TRUST FUNDS****Table IV-10 Authorizing Legislation**

	1996 Amount <u>Authorized</u>	1997 Amount <u>Authorized</u>	1997 Budget <u>Estimate</u>
Payments to Health Care Trust Funds (sections 201(g), 217(g), and 1844 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248)	Indefinite	Indefinite	<u>\$60,079,000,000</u>
Total Budget Authority			<u>\$60,079,000,000</u>

HEALTH CARE FINANCING ADMINISTRATION

PAYMENTS TO HEALTH CARE TRUST FUNDS

Table IV-11 Appropriations History Table

<u>Year</u>	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1987	\$20,357,000,000	\$20,826,000,000	\$20,826,000,000	\$20,826,000,000
1988	26,958,000,000	25,893,000,000	25,364,000,000	25,893,000,000
1989	32,100,000,000	31,227,000,000	31,227,000,000	31,227,000,000
1990	36,338,500,000	36,338,500,000	36,338,500,000	36,338,500,000
1991	37,056,000,000	37,056,000,000	35,335,000,000	35,335,000,000
1992	39,401,083,000	39,421,485,000	39,401,083,000	39,421,485,000
1993	43,201,713,000	43,963,192,000	45,962,862,000	45,962,862,000
1994	45,731,440,000	45,731,440,000	45,731,440,000	45,731,440,000
1995	37,546,758,000	37,546,758,000	37,546,758,000	37,546,758,000
1996	63,313,000,000	63,313,000,000	1/	61,899,000,000 ^{2/}
1997	60,079,000,000			

1/ There was no Senate allowance in FY 1996.

2/ This amount is based on the Seventh FY 1996 Continuing Resolution (P. L. 104-91).

*Supporting Tables***PAYMENTS TO THE HEALTH CARE TRUST FUND****Table IV-12 Funding Levels for Budget Activities****Federal Payment for Supplemental Medical Insurance**

Funding levels for the past five fiscal years were as follows:

1992.....	\$38,684,000,000
1993.....	\$45,478,000,000
1994.....	\$38,352,431,000
1995.....	\$36,955,000,000
1996.....	\$61,331,000,000

Hospital Insurance for the Uninsured

Funding levels for the past five fiscal years were as follows:

1992.....	\$584,000,000
1993.....	\$328,000,000
1994.....	\$458,000,000
1995.....	\$406,000,000
1996.....	\$358,000,000

Hospital Insurance for Uninsured Federal Annuitants

Funding levels for the past five fiscal years were as follows:

1992.....	\$37,000,000
1993.....	\$39,000,000
1994.....	\$48,000,000
1995.....	\$56,000,000
1996.....	\$61,000,000

Program Management Administrative Expenses

Funding levels for the past five years were as follows:

1992.....	\$116,485,000
1993.....	\$117,862,000
1994.....	\$128,440,000
1995.....	\$129,758,000
1996.....	\$149,000,000

HEALTH CARE FINANCING ADMINISTRATION

PAYMENTS TO HEALTH CARE TRUST FUNDS

Table IV-13 SMI Premium Estimates

CY	Current Law Premium	AGED		DISABLED	
		Actuarial Rate	Beneficiary Share of Monthly Cost	Actuarial Rate	Beneficiary Share of Monthly Cost
1996	\$42.50	\$84.90	25%	\$105.10	20%
1997	\$43.90	\$87.70	25%	\$111.30	20%

Supporting Tables

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
Program Management**

Table IV-14 Amounts Available for Obligation

	1995 Actual	1996 Policy D	1996 Current Estimate	1997 Estimate
Appropriation 2/.....		--	--	--
Enacted Recision Sections 113, 115 Reductions	(20,596,000)	--	--	--
Subtotal, Adjusted Appropriation.....	(8,391,000)	--	--	--
	(28,987,000)	--	--	--
Offsetting collections from:				
Non-Federal sources:				
HMO User Fees 3/.....	\$541,000	\$128,000	\$128,000	\$132,000
CLIA User Fees 3/.....	28,317,000	37,000,000	37,000,000	43,000,000
Subtotal, Non-Federal....	\$28,858,000	\$37,128,000	\$37,128,000	\$43,132,000
Receipts and Reimbursements from				
Trust funds:				
Trust funds transfer.....	2,071,570,000	2,004,851,000	2,004,851,000	2,060,140,000
HI Federal funds				
Limitation.....	<u>133,018,000</u>	<u>127,386,000</u>	<u>127,386,000</u>	<u>142,144,000</u>
Subtotal, receipts.....	\$2,204,588,000	\$2,132,237,000	\$2,132,237,000	\$2,202,284,000
Unobligated balance start of year.....	19,192,000	6,814,000	6,814,000	6,814,000
Unobligated balance end of yr.....	(6,814,000)	(6,814,000)	(6,814,000)	(6,814,000)
Unobligated balance lapsing.....	(22,477,000)	--	--	--
Total obligations.....	\$ 2,194,360,000	\$ 2,169,365,000	\$ 2,169,365,000	\$ 2,245,416,000

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

2/ Federal Funds appropriations are not requested in Program Management for FY 1997. Appropriations requested in the Payments to the Health Care Trust Funds account will reimburse the HI Trust Fund for the estimated Program Management Costs.

3/ Resources to fund the Administrative Cost activity are offset by the collection of HMO user fees under the User Charge Statute (31 U.S.C. 9701). The resources to fund CLIA activities are offset by the collection of CLIA user fees under the Public Health Service Act, Title XIII, section 353.

HEALTH CARE FINANCING ADMINISTRATION

PROGRAM MANAGEMENT

Table IV-15 Summary of Changes

1996 Appropriation/Policy	\$2,127,737,000
1996 Current Estimate.....	\$2,132,237,000
1997 Request.....	\$2,202,284,000
Net Change.....	\$70,047,000

	1996 Current Estimate Base		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in				
1. One quarter of FY 1996				
2.5 Percent Pay Raise.....				\$2,010,000
2. Three quarters impact of FY 1997				
3.0 Percent Pay Raise				6,025,000
3. Increase in Personnel Benefits.....				2,825,000
4. Promotion/Career Ladder etc.				
Increases.....				2,146,000
5. Other Services.....				<u>18,102,000</u>
Subtotal.....				\$31,108,000
B. Program				
1. Research.....		30,000,000		15,010,000
- Current Beneficiary Survey.....		10,000,000		300,000
2. Medicare Contractors.....		1,604,171,000		10,029,000
3. State Certification.....		145,800,000		28,000,000
4. Administrative Costs.....				
- HCFA On-Line.....		0		2,000,000
- Long Term Care		0		<u>1,000,000</u>
Subtotal.....				\$56,339,000
Total Increases.....				\$87,447,000
Decreases:				
A. Built-in				
1. Space Rental.....				(2,900,000)
B. Program				
1. Research.....				
- Rural Health Transition Grants.....		10,000,000		(10,000,000)
- Information Counseling.....		4,500,000		<u>(4,500,000)</u>
Subtotal.....				(14,500,000)
Total Decreases.....				(17,400,000)
Net Change.....				<u>\$70,047,000</u>
Non-Appropriated Program Management				
CLIA...(non-add).....		37,000,000		6,000,000
HMO User Fees.... (non-add).....		128,000		4,000

Supporting Tables

PROGRAM MANAGEMENT
Table IV-16 Budget Authority by Activity 1/

Activity	1993 Actual		1996 Policy <u>1/</u>		1997 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research.....		—		—		—
(Obligations).....		(\$76,193,000)		(\$54,500,000)		(\$55,310,000)
2. Medicare Contractors ..		—		—		—
(Obligations)		(1,584,942,000)		(1,604,171,000)		(1,614,200,000)
3. State Certification.....		—		—		—
(Obligations)		(145,512,000)		(145,800,000)		(173,800,000)
4. CLIA.....		—		—		—
(Obligations)	66	(33,638,000)	64	(37,000,000)	64	(43,000,000)
5. Administrative Costs....		—		—		—
(Obligations)	4,063	(354,075,000)	4,036	(327,894,000)	4,036	(359,106,000)
Total budget authority		—		—		—
Total obligations	4,129	(\$2,194,360,000)	4,100	(\$2,169,365,000)	4,100	(2,245,416,000)
HMO user fees.....		\$541		\$128		\$132
CLIA user fees.....		\$28,317		\$37,000,000		\$43,000

1/ Federal Fund appropriations are not requested in Program Management. Appropriations requested in the Payments to the Health Care Trust Funds account will reimburse the HI Trust Fund for the estimated Federal Funds allocation of HCFA's Program Management costs.

2/ Based on levels of the ninth CR, including an incremental policy adjustment.

HEALTH CARE FINANCING ADMINISTRATION

PROGRAM MANAGEMENT
Table IV-17 Authorizing Legislation

	1996 Amount Authorized	1996 Policy 1/	1997 Amount Authorized	1997 Budget Request 1/
Program Management:				
1. Research:				
a) Social Security Act, Title XI,				
- Section 1110.....	Indefinite	--	Indefinite	--
- Section 1115 2/.....	\$2,200,000	\$2,200,000	\$2,200,000	--
b) P.L. 92-603, Section 222.....	Indefinite	--	Indefinite	--
2. Medicare Contractors:				
Social Security Act, Sections 1816 & 1842.....	Indefinite	--	Indefinite	--
3. State Certification:				
Social Security Act, Title XVIII, Section 1864.....	Indefinite	--	--	--
4. CLIA 1988:				
Section 353, Public Health Service Act.....	Indefinite	--	--	--
5. Administrative Costs:				
Reorganization Act of 1953.....	Indefinite	--	Indefinite	--
Total appropriation.....		\$2,200,000	--	--
Total appropriation against definite authority.....		\$2,200,000	--	--

1/ Appropriations requests of \$149.0 million for FY 1996, and a request of \$142.0 million for FY 1997 in the Payments to the Health Care Trust Funds account will reimburse the HI Trust fund for the estimated Federal funds allocation of HCFA's Program Management costs.

2/ The total authorization for section 1115 is \$4.0 million. HCFA's portion of this amount is \$2.2 million.

Supporting Tables

PROGRAM MANAGEMENT
Table IV-18 Appropriations History Table

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation/ Policy	
1988					
Trust Fund Transfer	1,397,580,000	1,446,578,000	1,396,628,000	1,368,825,000	1/
1989	95,246,000	93,817,000	94,417,000	93,284,000	
Trust Fund Transfer	1,775,556,000	1,769,919,000	1,835,519,000	1,803,317,000	
Reduction			(1,133)		
1990	102,908,000	101,908,000	102,908,000	101,722,000	
Trust Fund Transfer	1,901,172,000	1,992,159,000	1,921,172,000	1,870,172,000	
Sequester				(26,197,000)	
1991	90,079,000	104,966,000	91,053,000	102,919,000	
Trust Fund Transfer	1,813,971,000	2,026,638,000	1,901,888,000	1,980,237,000	
1992 2/	--	--	--	--	
Trust Fund Transfer	1,891,027,000	2,282,055,000	1,982,901,000	2,274,055,000	
1993	--	--	--	--	
Trust Fund Transfer	2,006,389,000	1,985,497,000	2,165,062,000	2,179,900,000	
Reduction				(28,272,872)	
Transfer				(1,000,000)	3/
1994	--	--	--	--	
Trust Fund Transfer	2,254,783,000	2,172,598,000	2,192,414,000	2,189,960,000	
Reduction				(2,643,000)	
1995	--	--	--	--	
Trust Fund Transfer	2,191,800,000	2,183,985,000	2,207,237,000	2,207,135,000	
Reduction				(8,391,000)	
Rescission				(20,596,000)	
1996	--	--	--	--	
Trust Fund Transfer	2,253,794,000	2,134,566,000	--	1,749,971,000	4/
CR Annualized Rate				382,394,000	4/
1997	--	--	--	--	
Trust Fund Transfer	\$2,202,284,000				

1/ Includes \$105.0 million provided through P.L. 99-272 for payment safeguard activities, of which \$4.5 million was deferred by the FY 1988 Continuing Resolution.

2/ Beginning in FY 1992, funds requested in the Payments to the Health Care Trust Funds account will reimburse the HI Trust Fund for the estimated Federal Funds allocation of HCFA's Program Management costs.

3/ Transfer provided funds to the Food and Drug Administration to implement the Mammography Quality Screening Act, P.L. 102-539.

4/ Based on levels of the ninth CR, including an incremental policy adjustment.

HEALTH CARE FINANCING ADMINISTRATION

JUSTIFICATION

Table IV-19 Program Management
Account Summary

Activity	1996 Policy 1/	1997 Estimate	Increase or Decrease
Research.....	--	--	--
(Obligations).....	(\$54,500,000)	(\$55,310,000)	\$810,000
Medicare Contractors.....	--	--	--
(Obligations).....	(1,604,171,000)	(1,614,200,000)	\$10,029,000
State Certification.....	--	--	--
(Obligations).....	(145,800,000)	(173,800,000)	\$28,000,000
Administrative Costs.....	--	--	--
(Obligations) 2/.....	(327,894,000)	(359,106,000)	\$31,212,000
Total Budget Authority...	--	--	--
(Total Obligations).....	(\$2,132,365,000)	(\$2,202,416,000)	\$70,051,000
CLIA.....	--	--	--
(Obligations).....	(37,000,000)	(43,000,000)	\$6,000,000

1/ Base on levels of the ninth CR, including an incremental policy adjustment.

2/ Federal Funds appropriations are not requested for FY 1996 and FY 1997. Appropriations requested in the Payments to Health Care Trust funds account will reimburse the HI trust fund for the estimated Federal funds allocated for HCFA's Program Management costs. Obligations include HMO user fee collection estimates of \$128,000 in FY 1996 and \$132,000 in FY 1997.

Supporting Tables

PROGRAM MANAGEMENT

Table IV-20 Budget Authority by Object -2year

	1996 Policy 1/	1997 Estimate	Increase or Decrease
Total number of full-time permanent positions	4,036	4,036	--
Total compensable work years: Full-time equivalent employment	4,036	4,036	--
Full-time equivalent of overtime and holiday	9.0	9.0	--
Average ES salary	\$109,800	\$113,100	\$ 3,300
Average GS grade	12.8	12.8	--
Average GS salary	\$54,600	\$56,300	\$ 1,700
Average salary of ungraded positions	\$ 9,300	\$ 9,300	\$ -
Personnel compensation:			
Full-time permanent	\$217,606,000	\$226,793,000	\$ 9,187,000
Other than Full-time Permanent	4,942,000	5,183,000	241,000
Other Personnel Compensation	1,300,000	2,053,000	753,000
Personnel Benefits	\$37,907,000	\$40,732,000	\$ 2,825,000
Total Personnel Compensation and Benefits	\$261,755,000	\$274,761,000	\$ 13,006,000

1/ Based on levels of the ninth CR, including an incremental policy adjustment. Does not include CLIA FTEs (64 in FY 1996 and FY 1997) funded by CLIA User Fees.

HEALTH CARE FINANCING ADMINISTRATION

PROGRAM MANAGEMENT

Table IV-20 Budget Authority by Object - 2 Year (continued)

	1996 Policy 1/	1997 Estimate 2/	Increase or Decrease
Travel	\$3,000,000	\$3,000,000	-
Transportation of Things	\$210,000	\$210,000	-
Rents, Communications and Utilities: Rental Payments to GSA	\$24,900,000	\$22,000,000	(2,900,000)
Communications, Utilities, and Miscellaneous Charges	3,150,000	3,150,000	-
Printing and Reproduction	2,627,000	2,827,000	200,000
Consulting Services	6,400,000	10,400,000	4,000,000
Other Services	193,330,000	251,742,000	58,412,000
Purchases of Goods and Services from other Government Accounts	6,525,000	6,525,000	-
Operation of GOCOs	-	-	-
Medical care	1,602,371,000	1,612,200,000	9,829,000
Supplies and Materials	750,000	750,000	-
Equipment	\$528,000	\$528,000	-
Land & Structures	-	-	-
Grants, Subsidies, and Contributions	26,500,000	14,000,000	(12,500,000)
Insurance Claims and Indemnities	\$191,000	\$191,000	-
Total budget authority by object	\$2,132,237,000	\$2,202,284,000	\$ 70,047,000

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

2/ FY 1997 excludes HMO User Fees (\$132,000), and includes funding for HCFA on-Line (\$2,000,000); and the Long Term Care Initiative (\$1,000,000).

Supporting Tables

Program Management
CLIA

Table IV-21 Budget Authority by Object

	1996 Policy	1997 Estimate	Increase or Decrease
Total number of full-time permanent positions	64	64	—
Total compensable work years: Full-time equivalent employment	64	64	—
Full-time equivalent of overtime and holiday	0.4	0.4	—
Average ES salary	—	—	—
Average GS grade	12.8	12.8	—
Average GS salary	\$54,600	\$56,300	\$ 1,700
Average salary of ungraded positions	—	—	—
Personnel compensation: Full-time permanent	\$5,331,000	\$5,464,000	\$ 133,000
Personnel benefits	116,000	137,000	21,000
Total personnel compensation and benefits	\$ 5,447,000	\$ 5,601,000	\$ 154,000

HEALTH CARE FINANCING ADMINISTRATION

CLIA

Table IV-21 Budget Authority by Object - (continued)

	1996 Folio	1997 Estimate	Increase or Decrease
Travel	\$266,000	\$315,000	\$ 49,000
Transportation of Things	—	—	—
Rents, Communications and Utilities:			
Rental Payments to GSA	441,000	523,000	82,000
Communications, Utilities, and Miscellaneous Charges	714,000	846,000	132,000
Printing and Reproduction	53,000	63,000	10,000
Consulting Services	14,395,000	17,062,000	2,667,000
Other Services	15,634,000	18,531,000	2,897,000
Medical Care	—	—	—
Supplies and Materials	50,000	59,000	9,000
Equipment	—	—	—
Land & Structures	—	—	—
Insurance Claims and Indemnities	—	—	—
Total budget authority by object	\$ 37,000,000	\$ 43,000,000	\$ 6,000,000

Supporting Tables

PROGRAM MANAGEMENT

Table IV-22 Budget Authority by Object - 3 Year

	1995 Actual	1996 Policy 1/	1997 Estimate	Increase or Decrease
Total number of full-time permanent positions	4,099	4,036	4,036 *	--
Total compensable work years: Full-time equivalent employment	4,099	4,036	4,036	--
Full-time equivalent of overtime and holiday	9.0	9.0	9.0	--
Average ES salary	\$109,800	\$109,800	\$113,100	\$ 3,300
Average GS grade	12.8	12.8	12.8	--
Average GS salary	\$51,349	\$54,600	\$56,300	\$ 1,700
Average salary of ungraded positions	\$ 27,922	\$ 9,300	\$ 9,300	\$ -
Personnel compensation: Full-time permanent	\$200,786,000	\$217,606,000	\$226,793,000	\$ 9,187,000
Other than Full-time Perman	5,088,000	4,942,000	5,183,000	\$ 241,000
Other Personnel Compensati	3,448,000	1,300,000	2,053,000	\$ 753,000
Benefits for Former Personn	33,000	-	-	\$ -
Personnel benefits	\$36,713,000	\$37,907,000	\$40,732,000	\$ 2,825,000
Total personnel compensation and benefits	\$246,068,000	\$261,755,000	\$274,761,000	\$ 13,006,000

1/ Based on levels of the ninth CR, including an incremental policy adjustment. Does not include CLIA FTEs (66 in FY 1995; 64 in FYs 1996 and 1997) funded by CLIA User Fees

HEALTH CARE FINANCING ADMINISTRATION

PROGRAM MANAGEMENT

Table IV-22 Budget Authority by Object - 3 Year (continued)

	1995 Actual	1996 Policy 1/	1997 Estimate 2/	Increase or Decrease
Travel	\$7,328,000	\$3,000,000	\$3,000,000	\$ -
Transportation of Things	1,065,000	210,000	210,000	-
Rents, Communications and Utilities:				
Rental Payments to GSA	16,224,000	24,900,000	22,000,000	(2,900,000)
Rental Payments to Others	14,000	-	-	-
Communications, Utilities, and Miscellaneous Charges	6,158,000	3,150,000	3,150,000	-
Printing and Reproduction	29,064,000	2,627,000	2,827,000	200,000
Consulting Services	463,000	6,400,000	10,400,000	4,000,000
Other Services	246,178,000	193,330,000	251,742,000	58,412,000
Purchases of Goods and Services from other Government Account	-	6,525,000	6,525,000	-
Operation of GOCOs	-	-	-	-
Medical care	1,560,179,000	1,602,371,000	1,612,200,000	9,829,000
Supplies and Materials	2,518,000	750,000	750,000	-
Equipment	8,480,000	528,000	528,000	-
Land & Structures	-	-	-	-
Grants, Subsidies, and Contributions	36,776,000	26,500,000	14,000,000	(12,500,000)
Insurance Claims and Indemnity	\$172,000	\$191,000	\$191,000	-
	\$35,000	-	-	-
Total budget authority by object	\$2,160,722,000	\$2,132,237,000	\$2,202,284,000	70,047,000

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

2/ FY 1997 includes HMO User Fees (\$132,000); funding for HCFA on-Line (\$2,000,000); and the Long Term Care Initiative (\$1,000,000).

Supporting Tables

ADMINISTRATIVE COST *
Table IV-23 Budget Authority

Activity	FY 1996 Current Estimate	FY 1997 Estimate	Change
Personnel Compensation:			
Full-time permanent (11.1).....	\$ 222,937,000	\$ 232,257,000	\$ 9,320,000
Other than Full-Time Permanent (11.3).....	4,942,000	5,183,000	241,000
Other Personnel Compensation (11.5).....	1,300,000	2,053,000	753,000
Total Personnel Compensation (11.9).....	229,179,000	239,493,000	10,314,000
Civilian Personnel Benefits (12.1).....	38,023,000	40,869,000	2,846,000
Travel (21.0).....	3,266,000	3,315,000	49,000
Transportation of Things (22.0).....	210,000	210,000	-
Rental Payments to Others (23.2).....	-	-	-
Communications, Utilities, and Miscellaneous Charges (23.3).....	3,864,000	3,996,000	132,000
Printing and Reproduction (24.0).....	2,680,000	2,890,000	210,000
Consulting Services (25.1).....	20,795,000	27,462,000	6,667,000
Other Services (25.2).....	209,092,000	270,405,000	61,313,000
Purchase of Goods & Services from other Government Accounts (25.3).....	6,525,000	6,525,000	-
Operation of GOCOs (25.4).....	-	-	-
Research and Development Contracts (25.5).....	-	-	-
Medical Care (25.6).....	1,602,371,000	1,612,200,000	9,829,000
Supplies and Materials (26.0).....	800,000	808,000	8,000
Total.....	\$ 2,116,805,000	\$ 2,208,173,000	\$ 91,368,000

* FY 1996 total includes CLIA User Fees of \$37.0 million, and HMO User Fees of \$128,000; FY 1997 includes CLIA User Fees of \$43.0 million for FY 1997 and \$132,000 in HMO User Fees.

* This Chart reflects HHS' modified version of the OMB definition of Object Class.

HEALTH CARE FINANCING ADMINISTRATION

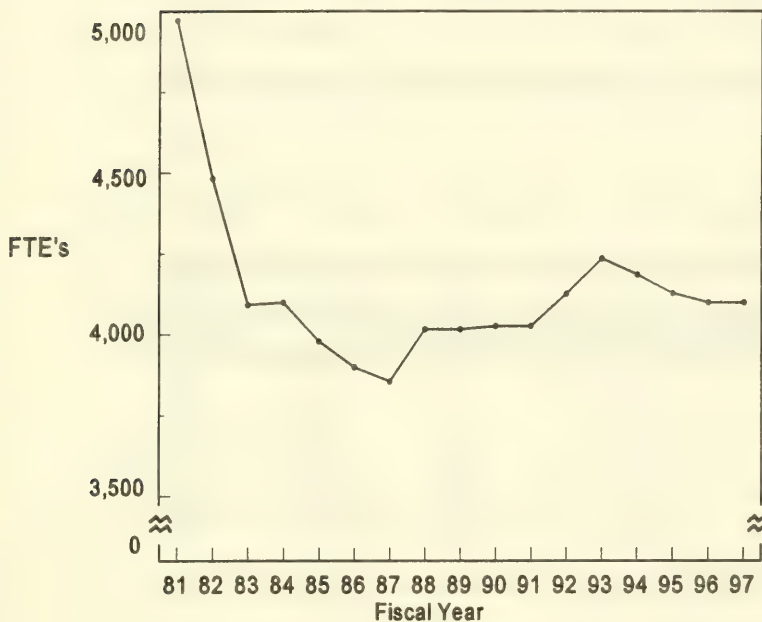
PROGRAM MANAGEMENT

Table IV-24 Detail Of Full-Time Equivalent (FTE) Employment

COMPONENT	FY 1995	FY 1996	FY 1997
	<u>Actual</u>	<u>Estimate</u>	<u>Estimate</u>
Office of the Administrator.....	18	18	18
Medicaid Bureau.....	190	190	190
Office of Hearings.....	34	34	34
Executive Secretariat.....	22	22	22
Office of Legislative & Inter-Governmental Affairs.....	51	51	51
Office of Managed Care.....	130	130	130
Equal Employment Opportunity Staff.....	16	16	16
Associate Administrator, External Affairs.....	63	63	63
Associate Administrator, Operations and Resource Management.....	3,015	3,016	3,016
Associate Administrator, Policy.....	560	560	560
Total, HCFA.....	4,099	4,100	4,100

Average GS/GM Grade

1993.....	12.8
1994.....	12.8
1995.....	12.8
1996.....	12.8
1997.....	12.8

*Supporting Tables***PROGRAM MANAGEMENT**
Table IV-25 FTE Ceiling**HCFA's FTE CEILING**
FY 1981 Through FY 1997

HEALTH CARE FINANCING ADMINISTRATION

PROGRAM ADMINISTRATION

Table IV-26 Detail of Positions

	FY 1995 Actual	FY 1996 Estimate	FY 1997 Request
Executive level I.....			
Executive level II.....			
Executive level III.....			
Executive level IV.....	1	1	1
Executive level V.....			
Subtotal.....	1	1	1
Total - Executive Level Salary	\$115,700	\$115,700	\$115,700
ES-6	1	1	1
ES-5	7	7	7
ES-4	9	9	9
ES-3	6	6	6
ES-2	12	12	12
ES-1	6	6	6
Subtotal.....	41	41	41
Total - ES Salary	\$4,201,000	\$4,264,015	\$4,384,473
GS-14/15.....	517	530	530
GS-13.....	1,310	1,314	1,314
GS-12.....	1,034	1,037	1,037
GS-11.....	185	186	186
GS-10.....	1	1	1
GS-9.....	284	285	285
GS-8.....	30	30	30
GS-7.....	237	238	238
GS-6.....	166	167	167
GS-5.....	177	178	178
GS-4.....	50	50	50
GS-3.....	34	34	34
GS-2.....	22	22	22
GS-1.....	16	16	16
Subtotal.....	4,063	4,088	4,088
Total full-time equivalent employment, end of year.....	4,137	4,150	4,150
Full-time equivalent (FTE) usage.....	4,099	4,100	4,100
	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>
Average ES level.....	2.8	2.8	3.0
Average ES salary.....	\$103,500	\$104,726	\$107,300
Average GS/GM grade.....	12.8	12.8	12.8
Average GS/GM salary.....	\$49,513	\$50,660	\$53,350

Supporting Tables

MEDICARE CONTRACTORS
Table IV-27 Change in Configuration

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>
<u>INTERMEDIARIES 1/</u>				
Blue Cross Plans	41	40	39	37
Commercials	6	6	6	6
Blue Cross Association	1	1	1	1
Total Intermediaries	48	47	46	44
<u>CARRIERS 2/</u>				
Blue Shield Plans	25	25	22	21
Commercials	8	8	8	8
Total Carriers	33	33	30	29
<u>DMERCs 3/</u>	4	4	4	4
TOTAL	85	84	80	77

1/ Intermediaries process Part A claims.

2/ Carriers process Part B claims.

3/ Durable medical equipment regional carriers (DMERCs) process claims and bills for medical supplies and equipment.

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE CONTRACTORS

Table IV-28 State Listing of Intermediaries

STATE OR TERRITORY	FISCAL INTERMEDIARY PART A	CARRIER - PART B
ALABAMA	ALABAMA BLUE CROSS MUTUAL OF OMAHA	ALABAMA BLUE SHIELD
ALASKA	WASHINGTON ALASKA BLUE CROSS	AETNA
AMERICAN SAMOA	HAWAII MEDICAL	AETNA
ARIZONA	ARIZONA BLUE CROSS MUTUAL OF OMAHA AETNA	AETNA
ARKANSAS	ARKANSAS BLUE CROSS	ARKANSAS BLUE SHIELD
CALIFORNIA	CALIFORNIA BLUE CROSS MUTUAL OF OMAHA AETNA	CALIFORNIA BLUE SHIELD
COLORADO	NEW MEXICO BLUE CROSS	NORTH DAKOTA BLUE SHIELD
CONNECTICUT	CONNECTICUT BLUE CROSS TRAVELERS AETNA	TRAVELERS
DELAWARE	DELAWARE BLUE CROSS	PENNSYLVANIA BLUE SHIELD
DISTRICT OF COLUMBIA	MARYLAND BLUE CROSS MUTUAL OF OMAHA	PENNSYLVANIA BLUE SHIELD
FLORIDA	FLORIDA BLUE CROSS MUTUAL OF OMAHA AETNA	FLORIDA BLUE SHIELD
GEORGIA	GEORGIA BLUE CROSS MUTUAL OF OMAHA	AETNA
GUAM	HAWAII MEDICAL	AETNA
HAWAII	HAWAII MEDICAL	AETNA
ILLINOIS	HCSC (ILLINOIS BLUE CROSS) MUTUAL OF OMAHA AETNA	HCSC (ILLINOIS BLUE SHIELD)
INDIANA	ASSOC INSURANCE (INDIANA B/C) MUTUAL OF OMAHA	ASSOC INSURANCE (INDIANA BLUE SHIELD)
IOWA	IAD (IOWA BLUE CROSS) MUTUAL OF OMAHA	IOWA BLUE SHIELD
KANSAS	KANSAS BLUE CROSS MUTUAL OF OMAHA	KANSAS BLUE SHIELD
KENTUCKY	ASSOC INSURANCE (KENTUCKY B/C)	ASSOC INSURANCE (KENTUCKY BLUE SHIELD)
LOUISIANA	MISSISSIPPI BLUE CROSS MUTUAL OF OMAHA	ARKANSAS BLUE SHIELD

*Supporting Tables***MEDICARE CONTRACTORS****Table IV-28 State Listing of Intermediaries (continued)**

STATE OR TERRITORY	FISCAL INTERMEDIARY PART A	CARRIER - PART B
MAINE	MAINE BLUE CROSS	MASSACHUSETTS BLUE SHIELD
MARYLAND	MARYLAND BLUE CROSS	TEXAS BLUE SHIELD
	MUTUAL OF OMAHA	PENNSYLVANIA BLUE SHIELD
MASSACHUSETTS	MASSACHUSETTS BLUE CROSS	
	MUTUAL OF OMAHA	
	AETNA	MASSACHUSETTS BLUE SHIELD
MICHIGAN	HCSC - MI (ILLINOIS BLUE CROSS)	
	TRAVELERS	
	MUTUAL OF OMAHA	HCSC - MI (ILLINOIS BLUE SHIELD)
MINNESOTA	MINNESOTA BLUE CROSS	TRAVELERS/AETNA
MISSISSIPPI	MISSISSIPPI BLUE CROSS	TRAVELERS
MISSOURI	MISSISSIPPI BLUE CROSS	KANSAS BLUE SHIELD
	MUTUAL OF OMAHA	GENERAL AMERICAN
MONTANA	MONTANA BLUE CROSS	MONTANA BLUE SHIELD
N. MARIANAS	HAWAII MEDICAL	AETNA
NEBRASKA	NEBRASKA BLUE CROSS	NEBRASKA BLUE SHIELD
	MUTUAL OF OMAHA	KANSAS BLUE SHIELD
NEVADA	MUTUAL OF OMAHA	
	AETNA	AETNA
NEW HAMPSHIRE	NEW HAMPSHIRE/VERMONT BLUE CROSS	MASSACHUSETTS BLUE SHIELD
NEW JERSEY	NEW JERSEY BLUE CROSS	
	AETNA	PENNSYLVANIA BLUE SHIELD
NEW MEXICO	TEXAS BLUE CROSS	
	SOUTH CAROLINA BLUE CROSS	AETNA
NEW YORK		EMPIRE
	EMPIRE BLUE CROSS	GROUP HEALTH INCORPORATED
	TRAVELERS	WESTERN BLUE SHIELD
NORTH CAROLINA	NORTH CAROLINA BLUE CROSS	CONN GENERAL (CIGNA)
NORTH DAKOTA	NORTH DAKOTA BLUE CROSS	NORTH DAKOTA BLUE SHIELD
OHIO	OHIO BLUE CROSS	NATIONWIDE
OKLAHOMA	OKLAHOMA BLUE CROSS	
	MUTUAL OF OMAHA	AETNA
OREGON	OREGON BLUE CROSS	
	MUTUAL OF OMAHA	AETNA

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE CONTRACTORS

Table IV-28 State Listing of Intermediaries (continued)

STATE OR TERRITORY	FISCAL INTERMEDIARY PART A	CARRIER - PART B
PENNSYLVANIA	PHILADELPHIA BLUE CROSS	
	PITTSBURGH BLUE CROSS	
	AETNA	PENNSYLVANIA BLUE SHIELD
PUERTO RICO	COOPERATIVA	TRIPLE-S INC.
RHODE ISLAND	RHODE ISLAND BLUE CROSS	RHODE ISLAND BLUE SHIELD
SOUTH CAROLINA	SOUTH CAROLINA BLUE CROSS	SOUTH CAROLINA BLUE SHIELD
SOUTH DAKOTA	IASD (IOWA BLUE CROSS)	NORTH DAKOTA BLUE SHIELD
TENNESSEE	TENNESSEE BLUE CROSS	
	MUTUAL OF OMAHA	
	AETNA	CONN GENERAL (CIGNA)
TEXAS	TEXAS BLUE CROSS	
	MUTUAL OF OMAHA	TEXAS BLUE SHIELD
UTAH	UTAH BLUE CROSS	UTAH BLUE SHIELD
VERMONT	NEW HAMPSHIRE/VERMONT BLUE CROSS	MASSACHUSETTS BLUE SHIELD
VIRGIN ISLANDS	COOPERATIVA	TRIPLE-S INC.
VIRGINIA	VIRGINIA BLUE CROSS	PENNSYLVANIA BLUE SHIELD
	MUTUAL OF OMAHA	TRAVELERS
WASHINGTON	WASHINGTON ALASKA BLUE CROSS	
	MUTUAL OF OMAHA	
	AETNA	AETNA
WEST VIRGINIA	VIRGINIA BLUE CROSS	
	MUTUAL OF OMAHA	NATIONWIDE
WISCONSIN	WISCONSIN BLUE CROSS	WISCONSIN PHY. SERVICES
WYOMING	WYOMING BLUE CROSS	NORTH DAKOTA BLUE SHIELD

MEDICARE STATE CERTIFICATION
Table IV-29 Voluntary and Involuntary Terminations

	FY 1993			FY 1994			FY 1995		
	Vol.	Invol.	Total	Vol.	Invol.	Total	Vol.	Invol.	Total
Skilled Nursing Facilities	48	18	66	54	21	75	42	19	61
Nursing Facilities	78	10	88	64	13	77	42	5	47
Intermediate Care Facilities for the Mentally Retarded	156	26	182	93	20	113	385	16	401
Hospitals	125	9	134	85	1	86	75	1	76
Home Health Agencies	138	9	147	155	7	162	180	13	193
Hospices	10	0	10	12	1	13	18	1	19
Outpatient Physical Therapy Comprehensive Outpatient Rehabilitation Facilities	83	2	85	85	0	85	99	6	105
X-Ray	15	0	15	13	1	14	13	0	13
End-Stage Renal Disease Facilities	17	1	18	10	0	10	15	0	15
Rural Health Clinics	31	0	31	21	6	27	99	3	102
Ambulatory Surgical Centers	61	2	63	76	2	78	99	3	102
	19	1	20	19	0	19	24	1	25
Total	781	78	859	687	72	759	1,091	68	1,159

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE MANAGED CARE

Table IV-30 Enrollment, Outlay, and Contract Growth

Enrollment	Year-end numbers (in thousands)					
	1992	1993	1994	1995	1996 Estimate	1997 Estimate
Type of Contract						
Risk	1,380	1,555	1,848	3,195	4,211	5,468
Other *	781	791	847	719	680	646
Total	2,161	2,346	2,695	3,914	4,891	6,114
Percent increase	--	8.5%	14.9%	45.2%	25%	25%
Risk as a percent of total enrollment	64%	66%	69%	82%	86%	89%
Enrollment as a percent of the program	5.9%	6.4%	7.2%	10.4%	12.6%	15.5%

Risk Contracts	Year-end numbers (in thousands)					
	1992	1993	1994	1995	1996 Estimate	1997 Estimate
Number of contracts	83	90	109	189	227	272
Percent increase	--	8%	21%	73%	20%	20%

Outlays	Year-end numbers (in millions)					
	1992	1993	1994	1995	1996 Estimate	1997 Estimate
Outlays (\$ in millions)	\$7,375	\$9,336	\$11,334	\$14,688	\$20,002	\$27,201
Percent increase	--	26%	21%	30%	36% **	36% **

* Category includes health care pre-payment and cost plans, as well as demonstrations.

** Approximately 69 percent of increase is attributable to the increase in enrollment, the remainder of the increase is attributable to the increase in payments to HMOs.

Supporting Tables

HEALTH CARE FINANCING ADMINISTRATION
Health Maintenance Organization Loan and Loan Guarantee Fund

Appropriation Language

For carrying out subsections (d) and (e) of section 1308 of the Public Health Service Act, any amounts received by the Secretary in connection with loans and loan guarantees under title XIII of such act, to be available without fiscal year limitation for the payment of outstanding obligations. During fiscal year 1997, no commitments for direct loans or loan guarantees shall be made.

HEALTH CARE FINANCING ADMINISTRATION

HEALTH MAINTENANCE ORGANIZATION

LOAN AND LOAN GUARANTEE FUND

Language Analysis

Language Provision**Explanation**

For carrying out subsections (d) and (e) of section 1308 of the Public Health Service Act, any amounts received by the Secretary in connection with loans and loan guarantees under title XIII of such act, to be available without fiscal year limitation for the payment of outstanding obligations.

Makes receipts of the fund available for the payment of obligations, i.e. prepayment premiums and interest subsidies.

During fiscal year 1997, no commitments for direct loans or loan guarantees shall be made.

This provision prohibits the issuance of additional direct loans or loan guarantees from being made to health maintenance organizations from the Health Maintenance Organization Loan and Loan Guarantee Fund.

GENERAL STATEMENT

The Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund served as a mechanism to provide working capital to HMOs in their initial operating periods when financial deficits were expected. Direct loans were made to HMOs from the Fund. These loans were then sold, with guarantees, to the Federal Financing Bank (FFB). The Fund also guaranteed the repayment of loans made by private lenders to HMOs.

Since HCFA was becoming increasingly more responsible for coordinated care, the Public Health Service's HMO program was transferred to HCFA in 1985. Included in this transfer was the HMO Loan and Loan Guarantee Fund.

The HMO Loan Fund is now dormant. The last loan commitments were made in 1983. In its period of active operation, the fund operated as a revolving fund. Direct loans to HMOs were sold, with a guarantee, to the FFB. The FFB purchase proceeds were then used as capital for additional direct loans.

Currently, HCFA collects principal and interest payments from HMO borrowers, and in turn pays the FFB. When loans are prepaid, HCFA rarely collects a prepayment penalty because most of the loan agreements do not have a prepayment penalty clause. However, when HCFA repays the loan to the FFB, a prepayment penalty is incurred. A shortfall is consequently created, and HCFA cannot immediately repay the loan to the FFB at the time that it is paid to HCFA. Shortfalls also occur because HCFA continues to pay FFB loan interest on these loans after receiving payments from HMOs and because of defaults on loans guaranteed by HCFA.

HEALTH CARE FINANCING ADMINISTRATION

**HEALTH MAINTENANCE ORGANIZATION
LOAN AND LOAN GUARANTEE FUND**

Table IV-31 Amounts Available for Obligation

	1995 Actual	1996 Current Estimate	1997 Estimate
Appropriation	\$15,000,000	-----	-----
Authority to borrow	-----	-----	-----
Offsetting collections from Federal sources	-----	-----	-----
Non-Federal sources: <u>Guarantee Loan Program</u>			
Offsetting collections	\$7,382,000	\$2,900,000	\$2,625,000
Interest paid to FFB	-1,430,000	-803,000	-664,000
Prepayment penalties	-1,340,000	-----	-----
Discount on sale of bond to FFB	-----	-----	-----
Redemption of debt	-18,337,000	-2,090,000	-2,069,000
Unobligated balance start of year	9,374,000	10,649,000	10,656,000
Unobligated balance end of year	<u>10,649,000</u>	<u>10,656,000</u>	<u>10,548,000</u>
Total obligations	<u>\$2,770,000</u>	<u>\$503,000</u>	<u>\$664,000</u>

**PROGRAM MANAGEMENT
PROPOSED LEGISLATION SUMMARY**

Health Coverage for the Temporarily Unemployed

Building on the President's insurance portability provisions, Federal funds will be made available to States to finance up to 6 months of coverage for unemployed workers and their families. The program would be available to those who had employer-based coverage in their prior job, are now receiving unemployment benefits, and have income below 240 percent of the poverty level. The States will have substantial flexibility in administering the program. The FY 1997 cost estimate is \$1.5 billion.

Health Care Purchasing Cooperatives

The President's plan proposes insurance reforms to help make health coverage more accessible, portable, and affordable. A small State grant program, \$25.0 million for FY 1997, will be established to accelerate the development of health insurance purchasing cooperatives. Such cooperatives can successfully reduce costs and increase choice for small businesses by allowing them to pool their employees.

HEALTH CARE FINANCING ADMINISTRATION

SIGNIFICANT ITEMS IN HOUSE, SENATE, AND CONFERENCE
APPROPRIATIONS COMMITTEE REPORTSFY 1996 House Appropriations Committee Report Language
104-209

Program Management

*Research, Demonstrations, and Evaluation*Item

Cost containment -- Health care represents one of the largest areas of expenditure for the Federal government. Most of that money is spent in hospitals, long-term care facilities, skilled-nursing facilities and clinics. Because of its interest in containing health care expenditures, the Committee encourages HCFA to review the training of administrators of health care facilities and report to the Committee what, if any, steps should be taken to improve that training.

Action Taken or to Be Taken

HCFA does not train administrators of health care facilities. HCFA does, however, require that health care administrators be licensed. Many State licensure programs include training requirements for facility administrators.

*Medicare Contractors*Item

Payment safeguards -- Medicare contractors are responsible for paying Medicare providers promptly and accurately. In addition to processing claims, contractors also identify and recover Medicare overpayments, as well as review claims for questionable utilization patterns and medical necessity. In addition, contractors provide information and technical support both to providers and beneficiaries

Supporting Material

regarding the administration of the Medicare program. In 1996, contractors are expected to process 822 million claims. Within the resources provided, the Committee urges HCFA to maintain payment safeguard activities to the maximum extent possible.

Action Taken or To Be Taken

The committee has urged HCFA to maintain funding for payment safeguard activities to the maximum extent possible. HCFA processes and pays claims for 37 million Medicare beneficiaries. With funding remaining virtually constant over the past three years and increasing claims volumes, it is increasingly difficult to set aside funds for payment safeguard activities. In the past, through the strict management of program dollars, funds have been re-allocated to provide more dollars for program integrity activities.

In the future, to maintain funding for payment safeguard activities, it is important that there be stable funding available throughout the year. The President has submitted a five year funding proposal, the Medicare Beneficiary Integrity System (MBIS), to provide steady, known funding for payment safeguards. Currently, funding for program safeguard activities comes from trust fund appropriations which are subject to domestic discretionary budget limits. With MBIS, this funding would be removed from the discretionary cap and allocated from the Trust Fund. MBIS allows HCFA to pursue more cost effective "pre-pay" program integrity strategies, thus shifting the emphasis away from frustrating, inefficient "pay and chase" strategies. MBIS will give HCFA the authority to enhance its oversight responsibilities and better protect the integrity of the Medicare Trust Fund.

*State Survey and Certification*Item

HEALTH CARE FINANCING ADMINISTRATION

Assessment of survey -- The Committee directs the Administrator to reexamine the Survey, Certification and Enforcement of Skilled Nursing Facilities, published at pages 56116 through 56252 in Volume 59, Number 217 of the Federal Register on November 10, 1994. The Committee is concerned that the regulations have imposed an excessively high standard that will cause many acceptably performing facilities to be out of compliance. The Committee understands that no monetary penalties will be applied in most cases for 90 days following the survey and encourages HCFA to use this time period to assess whether the regulations are having any unintended impacts. The Committee strongly urges the Administrator to consider reopening the rule-making process on this regulation if the findings of the analysis provide justification and to report to the Committee the results of its analysis by December 31, 1995.

Action Taken or To Be Taken

HCFA has examined the implementation of the Survey, Certification and Enforcement of Skilled Nursing Facilities in conjunction with the Committee's concerns. As ninety-six percent of all facilities are in substantial compliance at the completion of the survey or come into compliance by the close of the survey, we believe that the regulations have not imposed an excessively high standard on nursing homes. These nursing home participation requirements have been in place since October 1991.

HCFA has undertaken a variety of steps to assure that there have been no unintended consequences as a result of this regulation. Specifically, HCFA:

- ▶ instituted the Impact Assessment Advisors, an Administrator level group comprised of individuals representing consumers, providers, and private sector groups having an interest in the nursing home industry. This group has met several times and has several additional meetings planned;

Supporting Material

- ▶ established a “situation room,” with a manned telephone line, to monitor and review data for implementation of the Enforcement of Skilled Nursing Facilities regulation and to conduct reviews of survey findings; and
- ▶ conducted a Civil Monetary Penalty (CMP) proportionality study to determine if CMPs are both reasonable and proportional in the amount of penalty based on the blatancy of the noncompliance. The suspension of CMPs for certain levels of noncompliance is still in effect.

*Federal Administration*Item

Medicare/Medicaid data bank – The Committee directs that none of these funds may be used for the implementation of or planning for future implementation of the Medicare/Medicaid data bank. The Committee believes that the data bank as enacted should not be implemented. Since the Committee has not funded the data bank, and does not intend to fund the data bank in the future, penalties associated with the data bank’s employer reporting requirements should not be imposed.

Action Taken or To Be Taken

Pursuant to the Committee’s intention not to fund the data bank now or in the future, HCFA has no plans to establish or implement the Medicare/Medicaid data bank for fiscal year 1997.

HEALTH CARE FINANCING ADMINISTRATION

FY 1996 Senate Appropriations Committee Report Language
104-145

Program Management

*Research, Demonstrations, and Evaluation --*Item

Cost containment -- Health care represents one of the largest areas of expenditure for the Federal government. Most of that money is spent in hospitals, long-term care facilities, skilled-nursing facilities and clinics. Because of its interest in containing health care expenditures, the Committee encourages HCFA to review the training of administrators of health care facilities and report to the Committee what, if any, steps should be taken to improve that training.

Action Taken or to Be Taken

HCFA does not train administrators of health care facilities. HCFA does, however, require that health care administrators be licensed. Many State licensure programs include training requirements for facility administrators.

Item

Research, demonstrations, and evaluations -- The Committee expects the Health Care Financing Administration to provide a status report at next year's appropriations hearings concerning its plans for Medicare reimbursement for health care services provided using telemedicine. Specifically, the Administrator should be prepared to address reimbursement rates for telemedicine services, including a timetable for implementation.

Action Taken or To Be Taken

Supporting Material

HCFA is planning to implement a three year demonstration of Medicare payment for inpatient and outpatient telemedicine services. Waivers will be awarded to telemedicine sites operating under the demonstration. Under the waiver, primary providers and consulting specialists would be reimbursed for live interactive teleconsulting for evaluation and management (E&M) services.

HCFA is also conducting an evaluation of this demonstration focusing on how telemedicine services, specifically teleconsultation, affect access, quality, and costs of care in rural areas. These efforts should assist HCFA in developing a payment policy to integrate telecommunication technologies into the Medicare program.

Item

Nursing care in rural areas – The Committee urges HCFA to collaborate with the American Nurses Association and various nurse practitioner organizations to explore the extent to which these advanced practice nurses can provide primary care to rural and other medically underserved populations. The Committee requests that HCFA provide a report on the study findings within one year.

Action Taken or To Be Taken

HCFA is currently conducting a study of the availability of nurse practitioners in providing services to the Medicaid population, as well as to Medicare beneficiaries. This study will provide information on health care services provided by participating and non-participating nurse practitioners; the financial arrangements used to reimburse them for their services; the autonomy of their practices; and the environment in which they practice. A report from this study is due out in late spring.

HCFA is also currently implementing a three year demonstration project entitled the Community Nursing Organization (CNO) demonstration. HCFA was assisted in the design of the CNO project by Project Hope and the American Nurses

HEALTH CARE FINANCING ADMINISTRATION

Association. One of the primary objectives of the CNO demonstration is to test effectiveness and efficiency of nurse case management. Under this model, CNO nurses have increased responsibility for prescribing nursing care and coordinating a variety of Medicare-covered community based and outpatient care. Three of the four sites have a significant rural population for which care systems must be developed.

Item

Research, demonstrations, and evaluations -- The Committee believes that significant savings can be achieved by incorporating case management into the current fee-for-service Medicare program. In addition, the Committee believes that certain rural and under served areas of the country do not have the market penetration of managed care health plans to provide Medicare beneficiaries a choice of plans. The Committee, there, encourages HCFA to conduct a demonstration project to determine the cost effectiveness of providing for case management and continuum care for individuals entitled to Medicare benefits who have specific high cost chronic conditions.

Action Taken or To Be Taken

In 1993, HCFA implemented the Medicare Case Management Demonstrations. Three sites were chosen, and were designed to test the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. An evaluation of the demonstration sites is underway. The evaluation will test the operational feasibility and cost effectiveness of case management as a way of controlling Medicare beneficiaries' catastrophic health care costs in the Medicare fee-for-service sector. A final report is projected for late 1996.

Supporting Material

Item

Multi-year plan -- The Committee directs HCFA to prepare a multi-year plan for investing in and achieving the development of methodologies for risk adjustment, reinsurance, and carve-outs based on a pediatric population. This research agenda should include consultation with managed care plans, State Medicaid programs, and providers, including children's hospitals, experienced specifically in serving children with the most challenging health care needs. The research agenda also should plan for and disseminate the result of regular surveys of States' current methodologies for adjusting for pediatric care populations under Medicaid managed care.

Action Taken or To Be Taken

As part of HCFA's overall risk adjustment research plan, a number of projects were awarded in FY 1994 that address risk adjustment for the under 65 population, including children. These projects include a number of strategies including carve-outs and reinsurance. HCFA will analyze the results of these studies as they are completed over the next two years. Once results have been received, and commented on by appropriate HCFA partners, dissemination of the results will take place.

*Medicare Contractors*Item

Medicare billing -- The Committee is concerned that the Department is not using commercially available technology used in the private sector to reduce wasteful abusive billings to Medicare. The GAO has testified that the Department's present methods are costing the Medicare trust fund \$2,000,000 per day and, in addition, Medicare beneficiaries are paying additional costs as well. To assure that achievable savings are realized, the Committee directs that HCFA have its carriers purchase and utilize existing commercial automatic data processing equipment

HEALTH CARE FINANCING ADMINISTRATION

(ADPE), largely software, by March 30, 1996, which the GAO has indicated is a reasonable period. The Committee urges HCFA to act more quickly.

The ADPE should meet the following minimum requirements: (1) be a commercial item; and (2) surpass carrier's current software in ability to detect code manipulations, unbundling, global service violations, double billings, duplicate and mutually exclusive procedures performed on single day or over an extended period, and unnecessary use of assistants at surgery, and satisfy pertinent statutory requirements of the Medicare program. It is also expected that HCFA shall, not later than November 1, order a review of existing payment policies and billing code abuse to determine if revisions of or addition to those regulations, guidelines or guidance is necessary to maximize the benefits to Medicare and Medicare beneficiaries of the use of ADPE acquired under these provisions. The cost of purchasing and implementing the use of the ADPE is modest compared to the savings involved and the Committee expects that the funds shall be made available within the funds appropriated to HCFA.

Action Taken or To Be Taken

HCFA is taking a number of steps to address the concerns raised by the Congress. HCFA has examined data provided by the General Accounting Office (GAO) in support of their report on commercially available, off-the-shelf software applications. After analyzing this data, we are convinced that the Medicare program will not realize the impressive savings reported by the GAO without revising Medicare policies to be consistent with the policies inherent in these software applications. In fact, over 90 percent of the edits performed by the software were either in conflict with Medicare policy, included in HCFA's planned improvements, or currently being adjusted by Medicare carriers. Therefore, we do not agree with the decision for HCFA to implement commercial software into the current standard systems.

Supporting Material

HCFA has committed to evaluating these applications for use in the future Medicare Transaction System environment. To gain more information about commercially available, off-the-shelf software applications and their usefulness in a public program, such as the Medicare program, we plan to issue a request for information (RFI). Releasing this RFI will allow HCFA to survey the industry and evaluate the software packages against certain criteria including: how good is the software documentation, how readily available are the underlying policies, and how helpful are the messages returned explaining the impact of the edits.

HCFA has taken additional steps to prevent providers from manipulating service codes to inappropriately increase their Medicare payments. This "unbundling" inappropriately raises Medicare payments because the sum of the fees for the separate services is higher than the fee for the comprehensive service. We contracted with AdminaStar in August of 1994 to define correct coding practices using the American Medical Association Physicians' Current Procedural Terminology. Effective January 1, 1996 Medicare contractors implemented 84,000 correct coding combinations based on AdminaStar's recommendations. This enhancement allows for the automatic identification of inappropriate code combinations and properly determines payment by "rebundling" these claims under the proper comprehensive code.

HCFA has also signed an interagency agreement with Los Alamos National Laboratory (LANL) to develop prepayment software that will detect and deter improper claims, including service code manipulations. LANL is proposing to use several sets of advanced analytical techniques for fraud, waste and abuse detection which they have recently applied to government programs that are similar to Medicare.

Item

Carrier review -- The Committee is also concerned that HCFA's review of carriers does not place adequate emphasis on the carrier's success in detecting and stopping abusive billings and fraud. While the Committee does not believe it is

HEALTH CARE FINANCING ADMINISTRATION

appropriate at this time to provide carriers with direct financial incentives to detect fraud and abuse, it strongly urges HCFA to carefully review and weigh much more heavily the contractors' performance in this area in determining if contracts should be let or renewed. The Committee requests a report from HCFA on actions taken in this regard no later than April 1, 1996.

Action Taken or To Be Taken

HCFA reviews Medicare contractors through the contractor performance evaluation and regional office oversight. Beginning in 1994 and fully effective in 1995, HCFA totally changed its contractor performance review process placing more emphasis on outcomes, and abusive billing and fraud. Medicare contractors are instructed to maximize their fraud and abuse detection and deterrence efforts. We no longer set thresholds for contractors to meet because there was no incentive for contractors to maximize their efforts. HCFA now rewards the success of its contractors in an outcome based evaluation that encourages the maximization of efforts to stop abusive billing and fraud.

Also, our contractors work closely with the regional offices to optimize their performance in all areas, including fraud and abuse. The regional offices issue improvement reports to the contractors providing feedback regarding their performance. Detailed corrective action plans are then completed and followed through to ensure continuous process improvements.

*Federal Administration --*Item

Fraud detection -- A recent report by the General Accounting Office found that Medicare is not taking advantage of the latest computer technology (such as systems that employ artificial intelligence) designed to detect fraud. The Committee urges HCFA to move promptly to complete its review of this technology and incorporate it no later than January 1, 1996.

Supporting Material

Action Taken or To Be Taken

GAO asserted that Medicare's controls against fraud and abuse have not kept pace with today's health care environment. HCFA is in the forefront on the use of anti-fraud technology. We have funded the purchase of this type of software at several Medicare contractors and are actively reviewing the effectiveness of this technology. Additionally, this past year, HCFA sponsored 12 companies to exhibit and demonstrate their software at the national Medicare Fraud Conference.

With the implementation of the Medicare Transaction System (MTS), HCFA will integrate Medicare Part A, Medicare Part B, and managed care data into one system. Data files will be electronically examined to identify aberrant patterns and data discrepancies and MTS will be able to use off-the-shelf artificial intelligence software tools to detect probable or unusual patterns. HCFA's agreement with the Los Alamos National Laboratory will enhance the Medicare contractors ability to identify medically unnecessary or fraudulent claims before they are paid. The result will be an invaluable tool to monitor and prevent fraud and abuse across the spectrum of Medicare services.

Item

Federal administration -- The Committee is very disturbed to learn that even after being informed to the contrary by HCFA, that payments for surgical dressings continue without appropriate screens to protect the program against significant overpayments. HCFA expansion of the scope of the surgical dressings benefit without proper screens has led to even greater losses. The Committee urges HCFA to promptly correct this administrative shortcoming.

Action Taken or To Be Taken

HCFA agrees that appropriate prepayment edits should be used to prevent inappropriate payments when coverage policy changes, as it did for the surgical dressing benefit. When coverage for surgical dressings was expanded in March

HEALTH CARE FINANCING ADMINISTRATION

1994, the Durable Medical Equipment Carriers (DMERCs) were required by HCFA to implement certain item-specific screens. The DMERCs were also given the flexibility to implement screens to address problems specific to their regions. A detailed regional medical review policy, developed by the DMERCs to address the expansion of this benefit, became effective October 1, 1995.

Item

Federal administration -- The Committee has for 5 years raised its concern with the excessive paperwork burden placed by the Medicare Program on beneficiaries and providers and has previously directed HCFA to reduce paperwork by no less than 20 percent. HCFA has been slow to address this problem, but the Committee is pleased that important first steps were taken earlier this year to reduce Medicare paperwork. The Committee expects HCFA to take further significant steps to reduce paperwork and meet our previous directive to lower it by 20 percent.

Action Taken or To Be Taken

HCFA has been working closely with the medical industry and beneficiary representatives to design our forms and paperwork requirements in the least burdensome way. However, there is an inherent contradiction in trying to meet all the requirements of the law while simultaneously reducing the paperwork burden. This has been especially true this year because efforts to combat fraud and abuse have frequently resulted in the need to obtain additional information. For example, we want to ensure that durable medical equipment suppliers are legitimate businesses, i.e., that they have a real business address and telephone number and have not previously defrauded the government; and we want the doctor to verify that the items he ordered are indeed medically necessary, not options added by the supplier without his knowledge. Nonetheless, we take our paperwork management responsibilities seriously, and each of our forms is reviewed on a recurring three year cycle, and tightened up or redesigned to minimize the burden whenever possible.

THURSDAY, MAY 2, 1996.

ADMINISTRATION FOR CHILDREN AND FAMILIES

WITNESSES

MARY JO BANE, ASSISTANT SECRETARY, ADMINISTRATION FOR CHILDREN AND FAMILIES

ANN ROSEWATER, DEPUTY ASSISTANT SECRETARY FOR POLICY AND EXTERNAL AFFAIRS

DENNIS P. WILLIAMS, DEPUTY ASSISTANT SECRETARY FOR BUDGET, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MILLER [assuming chair]. Good afternoon. Mr. Porter will be coming sometime soon, and has asked us to go ahead and begin.

So Ms. Bane, if you would introduce your guests. We certainly know Mr. Williams, our regular guest before us. How many more days do you have here, Mr. Williams?

We're going to miss you. Glad to have you, Ms. Bane.

INTRODUCTION OF WITNESSES

Ms. BANE. Thank you, Mr. Miller.

I am accompanied by Dennis Williams, whom you know, and Ann Rosewater, who is the Deputy Assistant Secretary for Policy and External Affairs in the Administration for Children and Families.

OPENING STATEMENT

We're delighted to have a chance to present to you the President's budget request for the Administration for Children and Families. President Clinton has presented to the Congress a budget which addresses the concerns of Americans, serves their interests and creates opportunity, a budget that keeps faith with the long-standing commitments of the Department of Health and Human Services and the Administration for Children and Families.

In keeping with the Administration policy to increase support for programs that promote economic security and independence and that promote healthy development for our children, while at the same time working towards more efficient Government, our requested increases are targeted in areas that have shown significant payoffs.

The fiscal year 1997 budget request of \$34.3 billion for the Administration for Children and Families, which is an increase of \$1.9 billion over the fiscal year 1996 level, meets the challenge of continuing investments of previous years, which will lead to future service improvements, cost savings and ultimately citizens who are more independent.

The fiscal year 1997 budget request includes \$7.7 billion for ACF discretionary programs, an increase of \$686 million over the fiscal year 1996 appropriation. To create a positive future, we must build

on peoples' strengths, hopes and successes and act immediately and together to ensure strong foundations and safe passages for all children and youth, and to create stability and economic security for our families and communities.

HEAD START

One of the strong foundations for our children is the Head Start program, which gives children who are the most at risk a better chance of learning and success in life. In fiscal year 1997, we are requesting \$3.98 billion for the Head Start program. This funding level will support enrollment of nearly 800,000 children and their families, moving toward the President's goal of providing services to 1 million children by the year 2002.

Because early investment in children gives them the best chance of continued success, our fiscal year 1997 request also continues our commitment to the Early Head Start program, increasing enrollment in this area by 7,400 infants and toddlers between fiscal year 1995 and fiscal year 1997.

In addition, an investment in the Head Start program builds on our efforts of the past couple of years to ensure quality throughout the program. The performance of Head Start grantees is closely assessed through a strengthened monitoring system designed to improve program quality, as well as to ensure program compliance with required standards. Funds are targeted to provide training and technical assistance to poorly performing grantees. If grantees are found to have deficiencies which are not corrected within agreed-upon time frames, the Department of Health and Human Services will terminate their Head Start grant and seek a replacement agency to serve the community.

Since 1993, we've turned around 100 Head Start grantees that had been targeted as high risk grantees, developing action plans with them to reestablish them as quality Head Start programs. In addition, 40 grantees have been terminated or have relinquished their grants since 1993.

CHILD CARE

The President believes strongly that the best safety net for our children is and always will be strong families. And whether they are struggling to get jobs or keep them, we know that families need good child care to keep their children safe. The fiscal year 1997 request for the Child Care and Development block grant is \$1.05 billion. Over 750,000 children are currently served through the Child Care and Development block grant.

However, available resources fall far short of meeting the need for child care assistance. Currently, working poor child care funds reach only a relatively small percentage of the estimated 9 million children and families with a single working parent or dual working parents that could potentially be eligible for funding under the Child Care and Development block grant.

In December of 1994, the General Accounting Office reported that the availability of affordable child care is a decisive factor allowing low income mothers to work. They predict that providing full subsidy to mothers who pay for child care could increase substantially the proportion who work.

The Administration's fiscal year 1997 request will allow states to serve more families, keeping families off welfare and giving parents peace of mind, knowing that their children are safe and healthy in child care. We must continue to expand child care opportunities to those working parents who are struggling to remain out of the welfare system.

We must continue to build the quality of those opportunities so that children are in care that is safe, nurturing and supportive of their development. As we see welfare efforts requiring more and more parents to work, we must not abandon them in their efforts to care for their children.

ABUSED AND NEGLECTED CHILDREN

In addition, this budget reflects a clear Administration commitment to the safety, permanence and well-being of children who have been abused and neglected, or who are in danger of abuse and neglect. Each year, millions of children are the subject of a report of abuse or neglect. About 40 percent of these reports are substantiated, affecting nearly 1 million children a year.

At the end of 1995, over 450,000 children were in foster care, an increase of almost 42 percent since 1988. These are large numbers. And the children behind these numbers are the most vulnerable children in this society, whose safety, well-being and healthy development depends on how well our services respond to them and their families.

To strengthen and reform child protection and child welfare services, our fiscal year 1997 budget includes a number of key requests. First, \$419 million is requested for a range of discretionary programs that help states and local communities to protect children by strengthening families and preventing abuse, intervening when families are in crisis, and when necessary, making placement decisions to ensure children's safety.

Second, we request continuation of the Federal guarantee of support to states for eligible children in foster care and special needs children placed in adoption. These guarantees assure that states will be able to keep children safe even if they experience unpredictable increases in family crises and that children who cannot return safely to their biological homes have a chance at a loving adoptive home.

Third, support is requested for the establishment of a child welfare innovation program, which combines funding from training, research and demonstration, adoption opportunities and child abuse discretionary activities. These funds will be used strategically and flexibly to provide critical, knowledge based support to states and communities for research, demonstration, evaluation, training and technical assistance, designed to address emerging issues in the areas of child welfare and child abuse and neglect.

Finally, we propose consolidation of temporary child care and crisis nurseries into the community based family resource program. In keeping with the aim of bringing together small categorical programs to provide more flexibility and responsiveness in preventive and support services at the community level.

TEEN PREGNANCY

Adolescence is a developmental period with major milestones. And young people need special guidance and support to meet its challenges successfully and to move safely into adulthood. To help ensure a clear message of abstinence and responsibility, while simultaneously addressing the broader health, social, education and employment needs of young people, our budget includes a new \$30 million teen pregnancy prevention initiative.

Teen pregnancy rates remain alarmingly high in the United States. The consequences of this problem are quite serious. Eighty percent of children born to unwed teen mothers who have not completed high school live in poverty. Children of teenage parents are more likely than children born to older parents to die in their first year of life, to have lower cognitive achievement, to repeat a grade in school, to be victims of abuse and neglect, and to become teen parents themselves.

To address this serious social problem for our Nation, the Department will use the new funds to implement and evaluate promising prevention strategies in communities that have demonstrated a commitment to community problem solving. This effort is an important step forward to ensure safe passages for our Nation's adolescents.

PROGRAMS TO REDUCE CRIME

In an effort to reduce the unacceptable violence that threatens all of us and that cuts short too many lives, our fiscal year 1997 request includes \$29 million for programs to reduce violent crime. Of the funds requested, \$13 million will continue and increase funding for grants for the community schools, youth services and supervision grants program.

This program provides communities with resources to develop, coordinate and deliver academic and social enrichment which promote the positive and healthy development of youth, provide links to caring adults, and develop family and community support in communities beset by crime and violence. It includes \$15 million, along with funds included in the \$32 million family violence program, to support grants for battered women's shelters, which will provide immediate assistance to victims of violence and their dependents.

Four hundred thousand dollars will continue the activities of the National Domestic Violence Hotline. This national 24 hour toll-free hotline was first funded in fiscal year 1995 and began providing crisis assistance, counseling and local shelter referrals across the country on February 21st, 1996. In the first month, over 8,800 calls were answered. The hotline is averaging almost 300 calls a day.

WELFARE REFORM

For three years, the Administration and the Department have worked aggressively to overhaul the Nation's welfare system, both incrementally through State waivers and comprehensively through fundamental legislative reforms. We have granted waivers to 37 states, to provide them with the flexibility to move people out of welfare and into jobs. As a result, nearly 10 million welfare recipi-

ents, about 70 percent of all welfare recipients, are in households where the adults are being required to work and to take responsibility for their families and for their futures.

Welfare case loads are down by more than 1.4 million, a decrease of 10 percent since March of 1994. Child poverty is down, child support collections are up. In fiscal year 1997, \$12.5 million in child support collections are projected to be distributed to families and shared by governments, an 8 percent gain over fiscal year 1996 and a 50 percent gain since 1992. These incremental successes are encouraging, but with welfare reform, they are only a beginning.

The fiscal year 1997 budget submitted by the President includes his comprehensive welfare reform plan that promotes work and responsibility and achieves \$40 billion in program savings. The President's plan would replace the AFDC program with a conditional entitlement, with tough time limits and work requirements, while retaining a strong safety net for children. At the same time, it ensures that families will get the child care they need to hold a job and maintain a stable home.

In addition, the child support enforcement provisions include streamlined paternity establishment, new hire reporting, uniform interstate child support enforcement laws, computerized statewide collections, and drivers license revocations.

Mr. Miller, those are the highlights of the Administration for Children and Families 1997 budget request. I am pleased to answer any questions that you may have about it.

[The prepared statement of Ms. Mary JoBane follows:]

Statement
of
Mary Jo Bane
Assistant Secretary
Administration for Children and Families
Department of Health and Human Services
before the
Subcommittee on the Department of Labor, Health, and Human
Services, Education, and Related Agencies
Committee on Appropriations
U.S. House of Representatives

May 2, 1996

Mr. Chairman and members of the subcommittee, I am pleased to present the President's budget request for the Administration for Children and Families (ACF) for FY 1997. I am accompanied by Ann Rosewater, Deputy Assistant Secretary for Policy and External Affairs, and Dennis Williams, Deputy Assistant Secretary for Budget for the Department.

President Clinton has presented to Congress a budget which addresses the concerns of Americans, serves their interests, and creates opportunity; a budget that keeps faith with the long-standing commitments of this Department. In keeping with Administration policy to increase support for programs that promote economic security and independence and healthy development for our children, while working toward more efficient government, our increases are targeted in areas that have shown significant payoffs.

The FY 1997 budget of \$34.3 billion for the Administration for Children and Families, which is an increase of \$1.9 billion over the FY 1996 level, meets the challenge of continuing investments of previous years which will lead to future service improvements, costs savings, and ultimately citizens who are more independent. In a time of very tight resources, we are seeking increases for Head Start and the Child Care and Development Block Grant. In addition, we are proposing a new Teen Pregnancy Prevention Initiative targeting communities with high teen pregnancy rates which have demonstrated a commitment to community problem solving and have developed an appropriate infrastructure for implementing proposed strategies. These increases have been partially offset by a comprehensive budget strategy which includes combining programs to improve efficiency at all levels, and reducing the number of small categorical grant programs.

DISCRETIONARY PROGRAMS

The FY 1997 budget request includes \$7.7 billion for ACF discretionary programs - an increase of \$686 million over the FY 1996 appropriation.

To create a positive future, we must build on people's strengths, hopes, and successes, and act immediately and together to ensure Strong Foundations and Safe Passages for all children and youth and to create stability and economic security for our families and communities.

While the Administration for Children and Families funds a wide range of discretionary programs, I would like to take this opportunity to highlight a few of our key programmatic initiatives.

Approximately 60 percent of ACF's discretionary spending supports programs serving young children through the Head Start and the Child Care and Development Block Grant programs.

Head Start

One of the Strong Foundations for our children is the Head Start program which gives children who are the most at risk a

better chance of learning and success in life. In FY 1997, we are requesting \$3.98 billion. The FY 1997 program level for Head Start will support enrollment of nearly 800,000 children and their families, moving toward the President's goal of providing services to 1 million children by the year 2002. Because early investment in children gives them the best chance of continued success, our FY 1997 request also continues our commitment to the Early Head Start Program increasing enrollment in this area by 7,400 infants and toddlers between FY 1995 and FY 1997.

In addition, an investment in the Head Start Program builds on our efforts of the past couple of years to ensure quality throughout the program. The performance of Head Start grantees will be closely assessed through a strengthened monitoring system designed to improve program quality as well as to assure their compliance with required standards. Funds will be targeted to provide training and technical assistance to poorly performing grantees. If grantees are found to have deficiencies which are not corrected within agreed-upon time frames, HHS will terminate their Head Start grant and seek a replacement agency to serve that community.

Since 1993, we have turned around 100 grantees that had been targeted as high risk grantees, developing action plans to re-establish them as quality Head Start Programs. In addition, 40 grantees were terminated or have relinquished their grant since October of 1993.

Child Care and Development Block Grant

The President believes strongly that the best safety net for our children is - and will always be - strong families. And, whether they are struggling to get jobs or keep them, we know that families need good child care to keep their children safe. The FY 1997 request for the Child Care and Development Block Grant is \$1.05 billion.

Over 750,000 children are currently served with the Child Care and Development Block Grant. However, available resources fall far short of meeting the need for child care assistance. Currently, working poor child care funds only reach a relatively small percentage of the estimated 9 million children in families with a single working parent or dual working parents that could potentially be eligible for Child Care and Development Block Grant funds. In December 1994 the General Accounting Office reported that the availability of affordable child care is a decisive factor allowing low-income mothers to work. They predict that providing full subsidy to mothers who pay for child care could increase substantially the proportion who work.

The Administration's FY 1997 request will allow States to serve more families - keeping families off welfare and giving parents peace of mind - knowing their children are safe and healthy in child care. We must continue to expand child care opportunities to those working parents who are struggling to remain out of the welfare system. We must continue to build the quality of those opportunities so that children are in care that

is safe, nurturing, and supportive of their development. As we see welfare reform efforts require more and more parents to work, we must not abandon them in their efforts to care for their children.

Child Welfare and Child Protection

In addition, this budget reflects a clear Administration commitment to the safety, permanence, and well-being of children who have been abused or neglected or are in danger of abuse or neglect. Each year, millions of children are the subject of a report of abuse or neglect. About 40% of these reports are substantiated, affecting nearly 1 million children a year. At the end of 1995, over 450,000 children were in foster care, an increase of almost 42% since 1988. These are large numbers, and the children behind these numbers are the most vulnerable children, whose safety, well-being, and healthy development depend on how well our services respond to them and their families.

To strengthen and reform child protection and child welfare services, the FY 1997 budget includes a number of key requests:

- o \$419 million for a range of discretionary programs that help States and local communities to protect children by strengthening families and preventing abuse; intervening when families are in crisis; and when necessary, making placement decisions to ensure children's safety.
- o Continuation of the Federal guarantee of support to states for eligible children in foster care and special needs children placed in adoption. These guarantees assure that states will be able to keep children safe even if they experience unpredictable increases in family crisis; and that children who cannot return safely to their biological parents have a chance at a loving, adoptive home.
- o Establishment of a Child Welfare Innovation Program which combines funding from training, research and demonstration, adoption opportunities, and child abuse discretionary activities. These funds will be used strategically and flexibly to provide critical, knowledge-based support to states and communities for research, demonstration, evaluation, training and technical assistance designed to address emerging issues in the areas of child welfare and child abuse and neglect.
- o Consolidation of Temporary Child Care and Crisis Nurseries into the Community-Based Family Resource program, in keeping with the aim of bringing together small categorical programs to provide more flexibility

and responsiveness in preventive and support services at the community level.

Teen Pregnancy Prevention Initiative

Adolescence is a developmental period with major milestones, and young people need special guidance and support to meet its challenges safely and to move into adulthood successfully. To help ensure a clear message of abstinence and responsibility, while simultaneously addressing the broader health, social, education and employment needs of young people, our budget includes a new \$30 million teen pregnancy prevention initiative.

Teen pregnancy rates remain alarmingly high in the U.S. The consequences of this problem are serious. Eighty percent of children born to unwed teenage mothers who have not completed high school live in poverty. This is likely due to the fact that most of these children will continue to live in single parent households. Children of teenage parents are more likely than children born to older parents to die in their first year of life, have lower cognitive achievement, repeat a grade in school, be victims of abuse and neglect, and become teenage parents themselves.

To address this serious social problem for our nation, the Department will use the new funds to implement and evaluate promising prevention strategies in communities that have demonstrated a commitment to community problem solving. This effort is an important step forward to ensure safe passages for our Nation's adolescents.

Programs to Reduce Violent Crime

In an effort to reduce the unacceptable violence that threatens all of us and cuts short too many lives, our FY 1997 request includes \$29 million. Of the funds requested:

- o \$13.6 million will continue and increase funding for grants for the Community Schools Youth Services and Supervision Grant Program. This program provides communities with resources to develop, coordinate, and deliver academic and social enrichment which promote the positive and healthy development of youth, provide links to caring adults, and develop family and community support in communities beset by crime and violence.
- o \$15 million, along with funds included in the \$32 million Family Violence program, will support grants for Battered Women's Shelters which will provide immediate assistance to victims of violence and their dependents.
- o \$400,000 will continue the activities of the National Domestic Hotline. This national, 24-hour, toll-free

hotline was first funded in FY 1995 and began providing crisis assistance, counseling, and local shelter referrals across the country on February 21, 1996. In the first month over 8,800 calls were answered. The hotline is averaging almost 300 calls a day.

ENTITLEMENT PROGRAMS

For three years, the Administration and the Department have worked aggressively to overhaul the nation's welfare system both incrementally through State waivers, and comprehensively, through fundamental legislative reforms. We have granted waivers to nearly 40 States, to provide them with the flexibility to move people out of welfare and into jobs. As a result, nearly ten million welfare recipients - about 70 percent of all AFDC recipients - are in households where the adults are being required to work, and to take more responsibility for their families and their future. Welfare caseloads are down by more than 1.4 million, a decrease of 10 percent, since March 1994; child poverty is down and child support collections are up. Child support collections have been increased by using approaches such as income withholding, offset of income tax refunds, support guidelines and closer links to credit bureaus. In FY 1996, it is estimated that there will be a total return of almost \$4 for every dollar invested in the administration of the program. In FY 1997, \$12.5 billion in child support collections are projected to be distributed to families and shared by governments - an 8 percent gain over FY 1996. These incremental successes are encouraging, but they are only a beginning.

The FY 1997 budget includes President Clinton's comprehensive welfare reform plan that promotes work and responsibility and achieves \$40 billion in program savings. The President's plan would replace the AFDC program with a conditional entitlement with tough time limits and work requirements, while retaining a strong national safety net for children. At the same time, it ensures that families will get the child care they need to hold a job and maintain a stable home. In addition, the child support enforcement provisions include streamlined paternity establishment, new hire reporting, uniform interstate child support laws, computerized statewide collections, and drivers license revocation.

Conclusion

Thank you, Mr. Chairman. I will be happy to answer any questions you and the committee may have at this time.

HEAD START

Mr. MILLER. Let me start off with the area of Head Start. I have visited several Head Starts, including a migrant Head Start, in my area. And I think we have good ones in my area. But I was interested, you made a statement that in the past, since 1993, 40 Head Starts have lost their contract.

Ms. BANE. Forty Head Start programs have either been terminated by us or have voluntarily relinquished their status, because of quality problems.

Mr. MILLER. How do you come up with those quality problems? Is it fairly straightforward methodology you use?

Ms. BANE. We use a combination of methodologies. The main methodology we use is an on-site inspection, if you will, or an on-site monitoring. And for those visits, we use a standard instrument, which allows the people who are doing the monitoring to check to make sure that the elements of a quality Head Start program are in place there.

If they are not, we try to work with the program. We don't want to close programs arbitrarily, of course. We want to work with the program to turn around any problems that are there. But if we can't turn the program around, then we move to terminate or to replace the grantee.

Mr. MILLER. And you said 100 have been turned around?

Ms. BANE. That's correct. In the last couple of years.

Mr. MILLER. Prior to 1993, how many had lost their contract?

Ms. BANE. I wish I could answer that question for you.

Mr. MILLER. It is a rarity, I gather?

Ms. BANE. It was a rarity in previous years.

Mr. MILLER. The reauthorization in 1993 or 1994 allowed that, is that right?

Ms. BANE. The reauthorization strengthened our ability to do monitoring. We have also, as an administration, committed ourselves to improving the quality of the Head Start program. We have tightened up our monitoring. We have improved our ability to work with Head Start grantees. And I'm really proud of what we've been able to accomplish.

Mr. MILLER. It's a very fast-growing program. Do you have the numbers, Mr. Williams? In the past five to six, seven years, it's more than doubled in size, right?

Ms. BANE. That's correct.

Mr. MILLER. Some people question the program for growing almost too fast to absorb it. Where is most of the money going? Is it for new programs or is it just more money going into the existing programs, letting them expand? And how much is the additional cost under the new regulations you're coming out with? Is that going to increase the cost per student, per child?

Ms. BANE. I think the question of whether expansion was too fast was one that we were very concerned with a couple of years ago, when we tried to pay special attention to improving the quality of Head Start programs. And since 1993, we've put a big effort into improving quality at the same time we're expanding the number of children who are served.

Most of the money that's been an increase over the past couple of years goes to existing programs to expand their services to more children and also to improve quality. Over the last couple of years, Head Start programs have been able to improve the quality of their facilities, they've been able to improve the quality of their services by hiring additional people and improving what they have and so on. And so I think that we've done, a good job of balancing simple expansion in numbers with investments in quality.

The other thing we are very excited about, both this year, 1996 and next year, is the Early Head Start program. As one of the recommendations of the advisory panel on Head Start quality and expansion, which we convened in 1993, the reauthorization included the establishment of a new program for infants and toddlers, because of a recognition that those early years were so crucial. And our budget request for 1997 will allow us to expand the services of that program to a little over 25,000 children. So that is another place where I think that the funds are being well directed.

HEAD START EVALUATIONS

Mr. MILLER. With an 11 percent increase, are there any evaluations that show that the money can be well spent for that kind of an increase, any outside evaluations, any reports?

Ms. BANE. There's a whole bevy of outside evaluations. Very recently, the Packard Foundation convened a group of researchers to review the studies that have been done over the whole history of Head Start. That review of those studies was published very recently by the Packard Foundation.

These studies, as well as previous studies of Head Start, have documented the effects of Head Start on children's achievement, on their performance in school, on the fact that they don't repeat a grade so much. There are also studies which are longer term and show that when children get a head start in a high quality early education program they do better even as they move into adulthood.

PERFORMANCE MEASUREMENT

Mr. MILLER. How do you measure performance in the Head Start program, and what measurements are actually used to determine if the program is doing what it's supposed to be doing?

Ms. BANE. The main instruments that we use to measure quality in the Head Start program are the performance standards and the review instrument which is based on those performance standards.

Mr. MILLER. Are you changing that? I don't mean to interrupt you, but is that in the process of being changed?

Ms. BANE. We published revised performance standards for the Head Start program last month as a regulation. The regulation is out for public comment. Those new performance standards were revised in accordance with the Head Start reauthorization in 1994, and in accordance with a process which involved extensive consultation with early childhood experts, with Head Start programs, with parents, with a whole range of people who understand quality.

We have changed those performance standards to bring them up to date to reflect the new research and the new knowledge about what makes for a quality Head Start program. And as I say, we

got a great deal of input, both from experts and from the customers of the program, the parents themselves.

The new performance standards are an evolution from the old ones, retaining the same concepts, the same emphasis on quality, on providing comprehensive services, that the previous ones did. They reflect new knowledge and are presented in a better way.

TEACHER EDUCATION REQUIREMENTS

Mr. MILLER. What about the education requirements? Is there an education requirement that's going to make it a higher standard?

Ms. BANE. There is a requirement in the new performance standards that all Head Start programs have an educational curriculum, that they choose one which is responsive to their communities and to the particular needs of their students.

Mr. MILLER. I'm talking about the education requirements of individual teachers in the program.

Ms. BANE. There is a requirement in the performance standards, and in the law. Head Start teachers must have at least a child development associate degree or its equivalent, so that they have the appropriate training that they need.

Mr. MILLER. Is that new?

Ms. BANE. That was reaffirmed.

Mr. MILLER. So people are not going to be losing their jobs or anything over that?

Ms. BANE. We try to provide folks with the training opportunities to get that certification.

CHARITABLE CONTRIBUTIONS

Mr. MILLER. Head Start programs, it's my impression, do not seek support from the charitable side of the community, for contributions. What percentage do they accept, and how is that handled? It seems like there is a potential source of financial support to programs like Head Start, just like Goodwill or Salvation Army get support from local communities, they go out and raise funds. Is there much of that, and do they get to keep that, and how does that affect their budget? And is there any encouragement to do more of that?

Ms. BANE. There's a huge amount of volunteer participation in the Head Start program.

Mr. MILLER. Yes, time, but I'm talking about financial. I mean, obviously there are a lot of volunteers and a lot of parents.

Ms. BANE. There are a lot of volunteers and a lot of parents. In terms of financial contributions, they vary enormously from place to place. And let me see if we have any information on that that we can get to you.

[The information follows:]

Ms. BANE. While the majority of Head Start grantees depend on volunteer time and subsidized services from their community to generate the required match for their Head Start grant, many grantees also hold various fund raising activities. Some fund raising is accomplished through initiatives such as local bake sales; other community support is provided by donations of free materials and labor, allowing, for example, a Head Start program to renovate its facility at no cost to the Federal government. Head Start grantees also reach out in their communities to find community members willing to provide Head Start services, ranging from medical and dental examinations to janitorial support, at reduced or free rates. These community

contributions, while not always in cash, are nonetheless vital to helping Head Start meet the needs of its community and its enrolled families.

Ms. BANE. We've tried to work hard with Head Start grantees to strongly encourage them to be partners in their communities. Head Start programs shouldn't be isolated in the community. They shouldn't be isolated from the schools; they shouldn't be isolated from child care programs; they shouldn't be isolated from the community institutions that they are a part of.

I think that we are seeing lots and lots of examples of collaborations between Head Start programs and other parts of the community, so that they make very good use of resources that are available in the community to provide services to kids.

CARRYOVER BALANCES

Mr. MILLER. There are so many programs that help the underserved part of our society like Habitat for Humanity. And it seems like you should almost tap that source even more. I don't know if you're doing anything specific toward encouraging your programs, I talked to our local Head Start director one time about it. I haven't followed up on it, but I volunteered my help. But I think they need to look at that source.

Another question. Please explain why most Head Start grantees have accumulated unspent balances. Is there a connection between these unspent balances and the funding increases that Head Start has received in recent years? Are you concerned about the increasing absolute size of these unspent balances?

Ms. BANE. Not very. They are relatively small as a percentage of the total grant. I don't believe they have increased as a percentage of the funds that have gone out. In fact, I'm sure that's true. I think it reflects prudence. I mean, the fact that you have a little bit of carryover from the end of one year to the next reflects the fact that they're not spending money they don't have.

Obviously, we want programs to make full use of their funds and want to help them to do that. And we're tracking unspent balances carefully, giving particular attention to places where there are big unspent balances. At this time, this issue is not of great concern.

NON-FEDERAL SUPPORT

Mr. MILLER. For a local Head Start, a typical Head Start, how much of the money comes from the Federal Government versus other sources within the community? I mean, parents contribute some, I guess, volunteer time.

Ms. BANE. Certainly parents contribute volunteer time.

Mr. MILLER. How much non-Federal money goes into the support of an individual Head Start on average?

Ms. BANE. There is a requirement in the Head Start program that the local community provide either in-kind or in cash services to supplement the Federal program. And that requirement is I believe 20 percent. We'll check that and make sure and get back to you.

[The information follows:]

Ms. BANE. All Head Start grantees are required to provide at least 20 percent of the total cost of the Head Start program from non-Federal contributions. These contributions can be in cash or in kind by, for example, providing Head Start programs

free or subsidized space or professional services or by volunteering in the Head Start program.

Ms. BANE. All programs do that, and many do more than that.

Mr. MILLER. If someone contributed, you got a million dollar contributor to Head Start in your local community, does that hurt them for the next year's application?

Ms. BANE. No.

Mr. MILLER. I mean, they get to keep that?

Ms. BANE. Yes.

LIHEAP

Mr. MILLER. Sometimes there's a disincentive to even ask for all that.

Since you just got here, Mr. Riggs, I'll just continue a little bit longer, then I'll let you come in. Let me switch over to LIHEAP for a minute.

The justification indicates LIHEAP appropriations were provided in the early 1980s to offset continuing escalating energy costs. Those costs declined in the middle 1980s and have remained stable ever since. In real terms, how does the price of home heating for all three energy sources today compare to the price when this program was initially funded?

Ms. BANE. What I'd like to do, Mr. Miller, is submit that information for the record. I have a large number of tables here on energy crises for various sorts, which I have a feeling you don't want me to read.

[The information follows:]

Below are summaries and tables showing both current and constant dollar fuel price trends from 1973 through 1995.

In the data shown below, residential fuel prices for the three major fuel types--electricity, natural gas, and fuel oil--have been converted to dollars per million btu's (mmbtu) for the period of 1973 to FY 1995. Trends for a weighted average cost of energy (referred to as a composite average) were developed using weights calculated from the series of national residential energy surveys sponsored by the Energy Information Administration--the National Interim Energy Consumption Survey and the Residential Energy Consumption Survey.

Current Dollar Prices: Overall, composite average fuel prices increased steadily from 1973 to 1985, declined in 1986 and 1987, increased steadily through 1994, and then fell in FY 1995. With respect to the three fuel types:

- o electricity prices reached their first peak in 1985, fell in 1986, and then rose again from 1987 through 1994. Prices did not change between 1994 and FY 1995. The FY 1995 price level is about 8% above the 1985 peak.
- o natural gas prices reached their first peak in 1984 and 1985. Prices fell from 1986 to 1988, rose from 1988 through 1994, and then fell in FY 1995. Prices in FY 1995 were about 1% above the 1985 peak and 3% below the 1994 peak.
- o fuel oil prices reached their peak in 1981 and then fell continuously until 1988. Price rose in 1989 and 1990, and then fell from 1991 through FY 1995. Prices in FY 1995 were about 28% below the 1981 peak.

Constant Dollar Prices: When fuel prices are adjusted for inflation (using FY 1995 dollars), overall fuel prices rose steadily from 1973 to 1983 and have fallen steadily, except for a small increase in 1990. The FY 1995 composite average is less than the composite average for 1980. With respect to the three fuel types (see table 2):

- o electricity prices peaked in 1985 and have fallen steadily since that time.
- o natural gas prices peaked in 1983 and fell steadily until 1993. After increases in 1993 and 1994, prices fell in FY 1995.
- o fuel oil prices peaked in 1981, fell steadily until 1988, rose in 1989 and 1990, and then fell again from 1991 through FY 1995.

Table 1. Average price by fuel type and by year, current dollars per millions of British Thermal Units¹

Fuel Type	Calendar Year										
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Electricity	7.33	9.09	10.26	10.84	12.02	12.60	13.48	15.83	18.17	20.22	21.10
Natural Gas	1.29	1.43	1.71	1.98	2.35	2.56	2.98	3.68	4.29	5.17	6.06
Fuel Oil	1.64	2.18	2.72	2.93	3.32	3.53	5.08	7.02	8.61	8.36	7.77
Composite Average	2.82	3.44	3.99	4.32	4.89	5.19	5.96	7.39	8.85	9.70	10.68

Fuel Type	Calendar Year										
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
Electricity	21.98	22.86	21.69	21.69	21.98	22.27	22.86	23.74	24.03	24.33	24.62
Natural Gas	6.12	6.12	5.83	5.54	5.47	5.64	5.77	5.82	5.87	6.16	6.41
Fuel Oil	7.87	7.59	6.03	5.79	5.86	6.49	7.65	7.34	6.73	6.61	6.37
Composite Average	10.93	11.08	10.60	10.62	10.90	11.17	11.78	12.09	12.14	12.40	12.62

Fuel Type	Calendar Year										
	FY95										
Electricity	24.62										
Natural Gas	6.21										
Fuel Oil	6.24										
Composite Average	12.49										

4

¹Composite (all fuels) average is weighted, based on the amount of each fuel (i.e., electricity, natural gas, and fuel oil) purchased for residential use. Fuel prices were taken from tables 9.8, 9.9, and 9.11 of the Monthly Energy Review (December 1995, DOE/EIA-0035 (95/12)). Fuel costs were converted to dollars per mmbtu using conversion factors shown in tables A.2, A.5, and A.9 of the same issue of the Monthly Energy Review.

Average Fuel Prices In Current Dollars

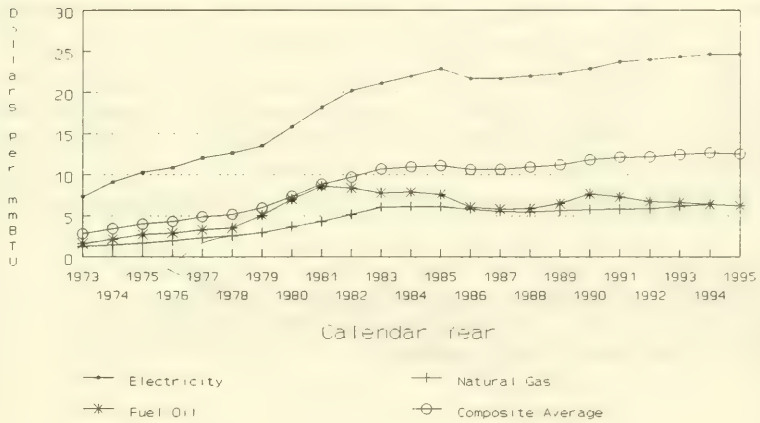


Table 2. Average price by fuel type and by year, constant FY 1995 dollars per millions of British Thermal Units²

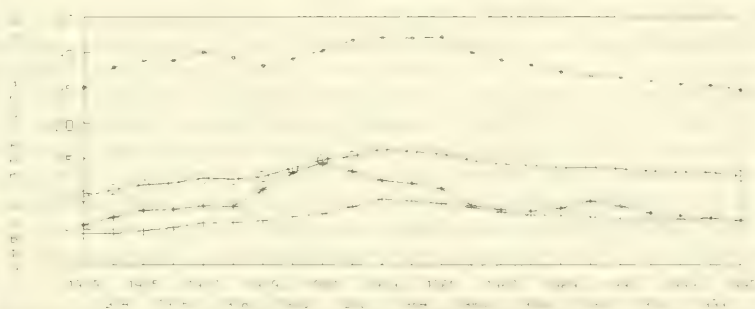
Fuel Type	Calendar Year										
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Electricity	24.98	27.90	28.87	28.85	30.02	29.26	28.11	29.08	30.27	31.73	32.08
Natural Gas	4.40	4.39	4.81	5.27	5.87	5.94	6.21	6.76	7.15	8.11	9.21
Fuel Oil	5.61	6.70	7.65	7.79	8.29	8.20	10.59	12.90	14.34	13.12	11.82
Composite Average	9.62	10.55	11.22	11.49	12.21	12.05	12.43	13.59	14.75	15.22	16.23

Fuel Type	Calendar Year										
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
Electricity	32.03	32.17	29.96	28.90	28.18	27.20	26.62	26.43	25.95	25.51	25.32
Natural Gas	8.92	8.61	8.05	7.38	7.01	6.89	6.72	6.48	6.34	6.46	6.59
Fuel Oil	11.46	10.68	8.33	7.72	7.51	7.92	8.91	8.17	7.27	6.93	6.56
Composite Average	15.93	15.59	14.64	14.16	13.97	13.64	13.71	13.45	13.11	13.01	12.98

Fuel Type	Calendar Year										
	FY95										
Electricity	24.62										
Natural Gas	6.21										
Fuel Oil	6.24										
Composite Average	12.49										

²Composite (all fuels) average is weighted, based on the amount of each fuel (i.e., electricity, natural gas, and fuel oil) purchased for residential use. Fuel prices were taken from tables 9.8, 9.9, and 9.11 of the Monthly Energy Review (December 1995, DOE/EIA-0035 (95/12)). Fuel costs were converted to dollars per mmbtu using conversion factors shown in tables A.2, A.5, and A.9 of the same issue of the Monthly Energy Review.

Fig. 1. Dependence of the rate of the reaction of the polymerization of α -methylstyrene on the concentration of the initiator.



1. $C_i = 0.001$ M; 2. $C_i = 0.0005$ M; 3. $C_i = 0.00025$ M; 4. $C_i = 0.000125$ M.

Mr. MILLER. Thank you.

Ms. BANE. I thought you might appreciate that. [Laughter.]

The summary answer to your question is that when you adjust fuel prices for inflation, overall fuel prices rose steadily from 1973 to 1983, and then they've fallen from 1983 to 1990, but are still above where they were in the mid 1970s. That's varied some by fuel source, and we'll get you that information.

Mr. MILLER. In the President's 1995 budget—were you here in 1995?

Ms. BANE. I was.

Mr. MILLER. Okay. The President's 1995 budget indicated that LIHEAP—I wasn't on the appropriations committee then. But at any rate, the budget request indicated that the LIHEAP program was poorly targeted and does not focus on energy crises and promoting independence of LIHEAP subsidy. I agree with that analysis. I believe that Congress should create a program that provides assistance through local providers.

Does the Administration intend to send up legislation to reform the program in accord with the analysis that was presented in the 1995 budget?

Ms. BANE. The LIHEAP program was reauthorized just a couple of years ago. And as you know, the LIHEAP program is a block grant program which gives enormous flexibility to the states to structure their energy programs in ways that meet the needs of the state. They can use LIHEAP funds in a variety of ways, and they do in fact use LIHEAP funds in a variety of ways to meet the needs of the families in their state. Our position is that the states are in a very good position to assess the needs of their State and to use LIHEAP funds in the most effective way.

Mr. MILLER. So you're not recommending any changes in LIHEAP?

Ms. BANE. We are not recommending changes in the LIHEAP legislation for fiscal year 1997. That's correct.

Mr. MILLER. Thank you.

Mr. Riggs, would you like to ask some questions?

Mr. RIGGS. I would, Mr. Chairman, thank you for recognizing me.

I want to welcome Commissioner Bane, or I guess I should refer to her as Secretary Bane.

Ms. BANE. That's correct.

EMERGENCY ASSISTANCE

Mr. RIGGS. First of all, I'd like to applaud you as an advocate myself of universal early childhood education for your continuing support of Head Start. But as you know, Madam Secretary, we do have some concerns that I believe you and I have had an opportunity to address personally. And the first thing I'd like to focus in on of course is the AFDC emergency assistance program, since unfortunately, we were unable to resolve that concern in the context of the Omnibus Appropriations Conference Report.

This has created a genuine crisis with the juvenile justice delivery systems in California and other states of the country. I recognize at the outset that this is a little bit like man bites dog, when you have a House Republican, conservative House Republican, complaining about Clinton budget cuts.

I'm sure you understand the concern that we have. In fact, if I might digress for just a moment, the week before our vote on the Omnibus Appropriations bill, towards the end of the Congressional April recess, I had a chance to visit the juvenile hall detention facility in Del Norte County in my district. I saw the appalling conditions there, and was informed by the county probation department head that the 4(a) EA funding was absolutely essential for them to continue their community placement program, and that without that funding, the crisis situation that already exists there in Del Norte County would be exacerbated.

I wanted to ask for your acknowledgement of this problem and get your thoughts on where we might go from here, how we might make up for this shortfall in funding. In the other committee I serve on, the Economic and Educational Opportunities Committee, we're taking up the reauthorization of the Juvenile Justice and Delinquency Prevention Act. I don't know if that's a vehicle to address this problem. But I'd like to get your thoughts.

Ms. BANE. As you know, Mr. Riggs, our problem was not that we didn't think these were good programs or useful things for states and counties to be doing. What we concluded was that we shouldn't be funding them under the emergency assistance program, given the Congressional intent. And as a Democrat, I feel strongly about this, too.

But when I came into this job, the emergency assistance program was spending about \$200 million a year. And by 1995, it was spending almost \$1 billion. That's a huge amount of growth. And because of that, we in the Department asked our Inspector General to look at those increases in expenditures and say what she thought was going on and what we should do about it. Her read, and I concurred in it, was that the expenses which, in most cases, were being shifted to the emergency assistance program by the states, were not expenses that Congress had in mind when the emergency assistance program was authorized.

So we moved to tell states that they should not use emergency assistance funds for those programs. And as you know, that is what we have done. We did give the states notice. We didn't take money back. But we did let them know.

This is not a judgment about the worth of any particular program, but about the law and about the appropriate use of this particular source of Federal funds. So I'm pleased to hear that you're exploring other possible opportunities.

Mr. RIGGS. Do you and the Administration have some ideas as to the proper forum or the proper vehicle to address this problem? I applaud the Administration, because I believe in giving credit where credit is due. I believe the Administration has in its own way made incremental reforms to the welfare system in America, although remaining, at least to date, opposed to structural or sweeping reforms.

But again, clearly, this is a major, major problem. And I don't know how we're going to resolve it. The one thing I do know is that just as a matter of public safety, we don't want some of these young people who have not been incarcerated because of the lack of juvenile justice infrastructure roaming around our community without these emergency assistance dollars, which again, have

been used to facilitate community placements in foster homes and group homes and the like. I don't know what we're going to do about this problem. And it's a growing problem.

Ms. BANE. Yes. I don't know the particular situation in your county, Mr. Riggs. I know a lot about it in general. In many states, the funds that were being claimed under emergency assistance in the last year or so, this particular source of claiming, had previously been provided by State and local governments. So it was not, in many cases, new services.

At least to some extent, we have to look at how states and communities were doing it before and what were the sources of funds. If there is a need for expansion in various places, I think it is not necessarily a Federal problem, but one that needs to be dealt with by states and communities.

Mr. RIGGS. Well, I'll let it go there, except to say, Madam Secretary, that right up until the 11th hour, the county in California that was most anxious about the loss of these funds, and was working with us to come up with acceptable language, again, in the context of the Omnibus Appropriations conference report, is Los Angeles County. So it's a major concern.

And just to make sure I have my statistics correct, the program grew from \$200 million a year—

Ms. BANE. In fiscal year 1991, the outlays for the program were \$167 million. And by 1995, the outlays for the program were \$941 million. We can get you the intermediate years, if that would be helpful to you.

[The information follows:]

Ms. BANE. The following are the actual Federal outlays for the Emergency Assistance program for FY 1991–FY 1995, as well as projected Federal outlay estimates for FY 1996 and FY 1997:

Fiscal year:

1991	\$167,000,000
1992	208,000,000
1993	225,000,000
1994	507,000,000
1995	941,000,000
1996	1,601,000,000
1997	1,801,000,000

LAKE COUNTY

Mr. RIGGS. Okay. Mr. Chairman, if I might pursue one other line of questioning.

Another situation that I've had a chance to discuss with Secretary Bane, is a situation involving another small county in my Congressional district, Lake County, which established a public-private partnership with a nationally known firm that does a lot of work as a Federal contractor called Maximus. As you well know, the Lake County government, the elected supervisors of the Lake County government, made a decision that they would allow a cash contribution from Maximus to count as the local match or cost share of non-Federal responsibility of Lake County.

That was the situation that 20 months into the contract with the Federal Government your agency decided to override. We still have this matter of the Lake County being ineligible for the Federal match, to the tune of \$97,000. And again, this is another situation where we're looking for some advice and some help here on how we

might proceed. And I'd like to get your thoughts on that particular situation.

Ms. BANE. As you know, Congressman Riggs, this was a thorny legal issue for us, an issue of exactly what private folks could contribute and when it became illegal. We had long legal discussions. I think that the judgement that we reached was reached after careful consideration and analysis.

What I have done, as I told you at the time that I would do, is to put a task force together to see what we could do. That task force is meeting. I'm going to wait for their advice before going much further with this.

Mr. RIGGS. I'll just conclude on this note. Perhaps you could ask the task force just to address the technical definition of the term donation.

Ms. BANE. Yes, they are clearly doing that.

Mr. RIGGS. My understanding is under existing appropriation law, you basically decided that that contribution was not acceptable as a donation, so we would like to change the current definition of donation and what is and is not considered to be an allowable donation.

Ms. BANE. The task force is indeed looking at that.

Mr. RIGGS. With that, Mr. Chairman, I have more questions related to both of the matters that I've addressed today, but I'll submit those for the record, for responses in writing.

Mr. MILLER. Mr. Hoyer?

AFDC WAIVERS

Mr. HOYER. Thank you very much, Mr. Chairman.

Secretary Bane, Secretary Rosewater, glad to be with you. I apologize for being late.

First of all, I was pleased to hear Mr. Riggs' observation with respect to the incremental reforms that are being made in welfare. The President indicated he wanted to change welfare as we knew it. I read in your statement that 70 percent of all AFDC recipients now who can work are working. And that clearly is the objective. I think the President articulated that in 1992, and obviously we're more than halfway there.

Ms. BANE. We're getting there.

Mr. HOYER. And Secretary Shalala observed in her testimony that we have, in 36 states, waivers?

Ms. BANE. In 37, actually.

Mr. HOYER. I'm behind the times.

Ms. BANE. Changes day by day.

Mr. HOYER. In 37 states, obviously, 75 percent of the states who are operating under waivers and moving forward on reforms themselves, one of which is Maryland, am I correct?

Ms. BANE. That's correct.

Mr. HOYER. We're pleased with that, and I want to congratulate you on moving, as one of the experts in this country on this issue, both from an academic and practical standpoint, I want to congratulate you and your department on the efforts you're making. I'm very pleased to see that.

HEAD START CANCELED GRANTEES

Now, I had another general question I think I got from your testimony that I read quickly, but I don't see it right this second. Head Start.

Ms. BANE. Head Start.

Mr. HOYER. In your testimony, you indicate that 40 grantees have voluntarily relinquished their grants. If you haven't already done so, I think, I'm trying to think of the question I want to submit to the record.

Let me ask it this way. Would you submit such information as you deem to be appropriate, which gives the committee the feeling, not the feeling, the understanding of why either some gave up voluntarily or were cancelled, without necessarily naming the individual programs. I may want to see that, but I don't know that I will ask for that for the record. Because I don't think it's necessary for the record.

Ms. BANE. Surely.

[The information follows:]

Ms. BANE. Head Start programs which have either had their grants terminated or have given up their grants because of quality shortfalls are grantees which were unable or unwilling to provide quality Head Start services. In some cases, it was because the grantee was providing inadequate health services, failing, for example, to assure that its children were receiving dental examinations or not following up to ensure that required treatment was being provided. Other programs were not fulfilling their responsibilities to Head Start parents, failing to abide by the requirements of Head Start's regulations that parents be integral players in the administration of all Head Start programs. Still other programs were lacking in fiscal and administrative systems, resulting in the improper use of Head Start grant funds, or were failing to exercise any management controls over the program. In short, these are programs which fail to live up to their obligations as Head Start providers. It is important to understand that we are not talking about perfection. We understand that many programs will have occasional problems in delivering required services. Most of these programs, however, quickly correct these problems and move forward with providing a high quality Head Start program.

Grantees which have been terminated are grantees with serious and systemic problems, frequently cutting across the many components of Head Start, which result in the Head Start program being of such unacceptably poor quality that it has lost the right to continue as a provider of Head Start services to this nation's disadvantaged children and families.

HEAD START PERFORMANCE MEASURES

Mr. HOYER. There are approximately 100 grantees who are under improvement suggestions within time frames. Let me ask you a general question first, process versus outcomes. We've talked about that a lot. I have recently read an evaluation which dealt a lot with process.

I think from my reading of the evaluation, it was probably appropriate in terms of process. But it dealt very little with outcomes, still. I'm wondering if you have a feel for how we're doing towards getting an evaluation of the product that our Head Start money is producing, as opposed to compliance with process that it may be getting.

Ms. BANE. Mr. Hoyer, as you know, we're taking a number of steps. We just published a new set of performance standards which we were asked to do by the 1994 legislation. Those performance standards are basic operating procedures. We made some movement in those performance standards toward measuring outcomes.

But I think I probably would agree with your assessment that basically, those performance standards are about how the program is run.

Simultaneously, though, with developing those performance standards, we've done two other things. The first is that we have convened a group of experts to work with us to develop what we're calling performance measures, and those measures will supplement the performance standards and be much more outcome oriented.

As I'm sure you know from your experience in Head Start and early education, how to develop outcome measures for young children and what to focus on are of considerable debate within the community of experts. Obviously, we want to look at health outcomes; we want to look at outcomes related to the child's social and emotional development; we want to look at outcomes related to the child's ability to do well in school.

As a result of that effort, we have developed a framework for performance measures and a suggested list of 40 performance measures that will provide the basis for a greater emphasis on outcome. We plan to push that forward as hard as we can. We're trying to do it simultaneously, with the education community, which is also working on performance measures.

That's one thing we're doing. And I think we're making progress. It's a hard task, and people are struggling with it.

Mr. HOYER. Do you have a target date for the accomplishment of the process for making those assessments, and the criteria for making them?

Ms. BANE. Mr. Hoyer, we have the framework, we have a number of instruments developed. We're piloting them this spring in selected Head Start programs. As a result of those pilots, we'll work next year to put them in place. I hope we can do all this within a relatively short time frame.

HEAD START RESEARCH

The other thing I wanted to mention that we're doing is investing in research, as well as in the development of these measures. There continue to be evaluations of the Head Start program. There has just recently been a new review sponsored by the Packard Foundation of all the research and evaluation efforts on Head Start. It's a very comprehensive review, going through the studies over nearly 30 years. Many of them are very recent and quite good.

But in addition to the studies that have gone on, we're making investments in new evaluations and research. We've been able to fund some quality centers to do research around the country. That research will feed into the development of the measures as well as provide more information on Head Start itself.

PROCESS REQUIREMENTS

Mr. HOYER. It's my thought, Madam Secretary, that the process requirements were somewhat difficult. The outcomes, or performance based measures will be excruciating.

Ms. BANE. They will.

Mr. HOYER. People are really held to the test, not people, but programs, programs are held to the test of, this is what we want,

in all the areas that you just mentioned. That will be a lot tougher. But we need to get to it.

Ms. BANE. I think it will be very difficult. I also think it's very important that we do that work and move in that direction.

COORDINATION OF FEDERAL PROGRAMS

Mr. HOYER. You and I have discussed, and you know I have a great interest in, and as you probably know, there is legislation pending that Mr. Shays and Mr. Hatfield are sponsoring, I don't know whether you're familiar with this legislation, which deals with the waiver of rules, regulations and statutes. It's very controversial.

Ms. BANE. Oh, right.

Mr. HOYER. And it goes much further than I had focused on, as you know, in my family child centers, which is Secretary Reilly's phrase, not mine.

But I am particularly interested in what you are doing within your department to see if we can coordinate AFDC, child care, Head Start and LIHEAP, family support and preservation, and such other programs as may not fall specifically under your aegis, but which are very much integrated into what you do, which may be in the Department of Education.

Ms. BANE. Yes.

Mr. HOYER. Or may be in the Department of Housing and Urban Development. I didn't include HUD, and I think I made a mistake, you know, in the task force that we set up. Mr. Chairman, we set up, I don't know whether you recall, a task force in this committee, and the legislation in 1994 put \$500,000 to it, for the purposes of looking at how we coordinate all these Federal programs.

And Mr. Livingston speaks a lot about 700 educational programs, this, that and the other. My idea is, from the Federal level, put them together so that the local folks don't have to figure it out. We figure it out for them. We have Sally, age 3, and this is what we can do for her. Not so the locals have to go up stovepipe programs like this, but that the Federal funds will come down like this and rationalize their own programs.

What are you doing on that?

Ms. BANE. Well, we're doing many things within the Department. One thing I'd like to mention specially, though, is an effort out of the Domestic Policy Council at the White House, which has launched an initiative which they are calling Partnerships for Stronger Families. Through that initiative, they are bringing together all the relevant departments to work with local communities.

To launch that, they had a working conference a month or so ago, where they brought together 14 states. The representatives from the States included community people and State people, people from education and from a variety of programs to work together to brainstorm about how better collaboration could come about. That conference will provide the opportunity for good work that we can do as an administration to make it easier for communities to work together.

Within ACF, we've done a number of things to try to encourage Head Start programs to work with their local child care programs,

to make sure that both programs are coordinated with local schools to meet their needs in both areas.

As you noted, we have granted 37 waivers. Actually we have granted 60 waivers to 37 states to do welfare reform. In many of those waivers, folks are able to bring together programs in different ways. Another initiative that I think is very important in this respect is the empowerment zone, enterprise community initiative, under which communities in distressed areas do a plan where they look at their service needs and their economic development needs and, as a part of that plan, can request greater flexibility from the Federal Government along a variety of programs, in order to bring things together.

Mr. HOYER. I think the—who's coordinating that out of the White House?

Ms. BANE. Carol Rasco.

Mr. HOYER. I'm sure I've used my time, Mr. Chairman, you're being very tolerant, I appreciate that.

Mr. Obey and Mr. Stokes, Ms. Pelosi are yielding me their time. [Laughter.]

Mr. HOYER. It says here in fine print——

[Laughter.]

CHILD CARE/EARLY HEAD START PROGRAM

Mr. HOYER. You mentioned child care, obviously a critically important component. Zero to three, Head Start, what are we doing on that and where are we? Obviously, as you know, I'm a real bug on this. The family child center, which some people now refer to as the local elementary school, is going to be the repository ultimately of this, so we don't have parents who have to move the child at 2:30 or 3:00 o'clock or 3:30 from school setting to child care setting when they're at work.

It's a horrendous problem, and we need to fix it. And the way we fix it is these family child centers, in my opinion. How are we doing? And of course, the Head Start people are wildly enthusiastic about this, as you know.

Ms. BANE. Many of them are.

Mr. HOYER. I know.

Ms. BANE. No, they really are. They really are.

Mr. HOYER. But how are we moving along on zero to three, as it relates to this particular problem, which I think the schools ultimately are going to have to be the solvers of?

Ms. BANE. Let me speak to the Early Head Start program, which, as you know, is something that we're very pleased and proud about. The advisory committee recommended an Early Head Start program. The Head Start legislation in 1994 established it. This year and next year we'll be putting aside 4 percent of the total Head Start appropriation to fund Early Head Start programs.

We think that there will be a little over 25,000 children who will be served by Early Head Start programs in 1997. Those are very innovative programs which work with families, which work with communities and bring things together in a very innovative and creative way. We're delighted about it.

A number of these Early Head Start sites are engaging in partnerships with either center based or family child care. That's one

of the things we're focusing on. Our research will also focus on those to see how they work. The issue of coordination between Head Start and child care in schools is again one that we are diligently working on with our grantees and communities. Sometimes extended child care is located in the school, and sometimes it's a parent center. It's done in a variety of ways.

I think, as you note, that the child care problem is so crucial. Especially as we develop welfare reform and as more and more low income families are two worker families. Child care has become so important. I think all these things that we can do to bring programs together are going to be important.

Mr. HOYER. Thank you, Mr. Chairman. And bringing these programs together, if I might make a comment to Secretary Bane, Mr. Chairman, as you probably heard, I was somewhat disappointed with the initial efforts of the task force. The reason I was disappointed with the initial efforts of the task force, and I think particularly my friends on the Republican side of the aisle will be interested in this, because they focused on exactly this issue. Correctly so, in my opinion.

The task force sort of took the tack of what can the locals do, put a consortium together there to get everybody together.

Ms. BANE. Right.

Mr. HOYER. My focus was, what can we do at the Federal level to rationalize our programs, not what can the locals do. It's us that have all these myriad different programs. It's us that have created program A, B, and C, all designed to help Sally.

And so what I think we need to do is not to ask the locals or the states to get their act together. I don't think our act is together. And I really think we need to do that. And as Democrats, you and I, that defend these programs, and say, look, they ought to really be done at the Federal level, because we have a Nation, yes, we have Californians and Floridians and Marylanders, but we have a Nation, we are Americans, and these kids are very, very mobile.

Ms. BANE. Right.

Mr. HOYER. And they'll be in Maryland today, Florida tomorrow and California the next day. No, I guess they'll start out in California, then they'll move to Florida, then come to Maryland. [Laughter.]

But we need to do that so that not our local folks, but we are saying, we've got all these resources and you can get them very easily. That's why I have sympathy to the block grant, as you know, because at least it does that.

My problem with the block grant is, and I tell my friends, Republicans, they're usually used for the purposes of cutting resources.

Ms. BANE. Right.

Mr. HOYER. I think that's dead wrong, and Head Start, I think we need to double it. How many eligible children are there?

Ms. BANE. There are probably 2 million.

Mr. HOYER. We want to get to 1 million, half, by 2002.

Ms. BANE. Right.

Mr. HOYER. That means 1 million are falling into the cracks.

Ms. BANE. Exactly.

Mr. HOYER. Mr. Chairman, you've been very tolerant, and I thank you.

DUPLICATION OF EFFORTS/CONSOLIDATION

Mr. MILLER. Let me follow up on Mr. Hoyer's question, with one other question I wanted to ask. How do you keep from having duplication of programs, especially with a lot of small ones? One of the agencies before us yesterday was talking about the clustering of their programs. They are taking 50 programs, clustering them down to 4.

What are you doing along the area of consolidations, especially of the smaller programs? And then I know you have one new program, the teenage pregnancy program. For example, is that duplicating anything? There is already one program in the Public Health Service Act, which is funded.

Are we duplicating another program by creating a new one? And how do we make sure we don't just expand like that? Can you address the issue of consolidations, and specifically on the teenage pregnancy one? Is that duplicating another program? Is the other program needed? Should we fold it into this one?

Ms. BANE. On the issue of consolidations, our budget request for 1997 does propose a number of consolidations to try to deal with this very issue.

A couple that I would note are in the area of child welfare. We're proposing to bring together four programs in the child welfare area, child abuse discretionary activities, child welfare training, child welfare research and demonstration and adoption opportunities, so that it can be a more flexible program.

There was a consolidation of some programs a couple of years ago into the community based resource center program. We're proposing to consolidate two additional programs for the very purpose of dealing with some of these problems more efficiently.

TEEN PREGNANCY

On teen pregnancy, the question of what makes this teen pregnancy initiative different from other programs is an important question. What makes this new effort different from the other HHS programs is its focus on evaluation and learning. It is meant to be a program which demonstrates and evaluates and develops knowledge about teen pregnancy prevention, which is the key concept here. Many of the other programs that we have are not directed at preventing teen pregnancy.

We developed this program in response to and building on a very comprehensive review of research, which we commissioned in the last year to look at teen pregnancy and what could be done about it. I think the thing that was striking about the review of the research was that its conclusion that there's no single intervention that seems to work to prevent teen pregnancy. The best programs are programs that are comprehensive, that deal not only with messages about abstinence and responsibility, but that provide health services when necessary, that provide opportunities to kids, so that there are other things to do besides becoming a parent. These comprehensive approaches to teen pregnancy are the approaches that the research seems to suggest will have effects.

We need to learn much more about how to make those happen. This program is meant to provide resources to communities where

there is some infrastructure, so that they can test these new comprehensive approaches and we can learn from them. We really see this as a complement to some of the other programs, and as a way for communities to develop comprehensive approaches that are genuinely geared to prevention.

Mr. MILLER. That's a goal everybody would agree with. The question is, is it duplicating some other Federal program that may not even be in your department or your jurisdiction? It could be in the Department of Education. How do we know we're not duplicating? You know, should we consolidate programs or expand existing programs to accomplish the same goals? How do we feel assured before we create a new program that it can't be accomplished through some existing organization?

Ms. BANE. We did try to do a comprehensive review of the programs that existed. For example, we know that within HHS we have a healthy start block grant program, we have CDC programs, we have an adolescent family life program. On the health side we did a review which looked at programs in other departments as well.

We concluded from that review that an approach which focuses on comprehensive services and focuses on prevention and focuses on learning and evaluation is needed. Our conclusion was that it was not in fact duplicative, but that it would provide a new kind of approach and a new kind of effort to the serious problems.

Mr. MILLER. Could you submit something to explain why there's no duplication, and what other Federal programs are there so that we see there's not a duplication?

Ms. BANE. Surely.

[The information follows:]

This effort differs from other HHS programs in that evaluation and learning are its principal goals and that it is an effort concentrated and focused on teenage pregnancy prevention interventions.

Other HHS programs are making significant contributions in the area of teenage pregnancy prevention. This program's concentrated focus on pregnancy prevention interventions and more rigorous evaluation makes it distinct.

Healthy Start/MCH Block Grants.—Targeted to improving maternal and infant outcomes—teenage pregnancy prevention is not its primary mission.

Adolescent Family Life.—Abstinence-based prevention and therefore limited in its ability to cover many comprehensive approaches. Statutorily limited in the amount of money that can be dedicated to research.

CDC Community Coalition Partnership Programs for the Prevention of Teen Pregnancy.—Principally geared toward helping communities develop partnerships and coalitions. (The new program is aimed at advancing those communities that have successfully developed this kind of infrastructure).

Mr. HOYER. Mr. Chairman, on that issue, would you yield for a moment?

Mr. MILLER. Sure.

Mr. HOYER. Madam Secretary, you and I attended a conference down in Florida I guess, what, four or five years ago, together? Spent three or four days discussing issues of this type?

Ms. BANE. That was before I was a Federal employee, let the record show. [Laughter.]

Mr. HOYER. Would that have made a difference, you wouldn't have come if you were a Federal employee?

Ms. BANE. I wouldn't have been able to afford it.

Mr. HOYER. Charles Murray was there, as you recall.

Ms. BANE. Right.

Mr. HOYER. And while I have problems with Mr. Murray's suggested solution, I have great sympathy with his statement of the problem. You mentioned, for instance, as to the reasons. I'm convinced that one of his thoughts is absolutely correct. There is no adverse peer pressure sanction for teen pregnancy today. You've heard my story about Bladensburg High School.

Ms. BANE. Right.

Mr. HOYER. One hundred eleven young women either were pregnant or had children in one high school in Prince George's County in 1993. One high school.

Ms. BANE. Right.

Mr. HOYER. When I went to high school, I am sure there was somebody who got pregnant, maybe one or two. I never knew about it. Why? Because it was not acceptable behavior.

Ms. BANE. Right.

Mr. HOYER. One of the problems in my opinion is that we are too tolerant of behavior which is clearly dysfunctional in the sense that you cannot cope with it and have a successful family unit for society. And I hope we have a component for that.

Ms. BANE. Absolutely.

Mr. HOYER. Those of us who, I like to believe I am a tolerant person. I believe that under our constitution we require tolerance of one another. That does not mean that I need to not make judgments of what behavior I believe is dysfunctional and negative in its impact, not just on the individual, but on society. We need to have a component of that.

Ms. BANE. No, I think that's absolutely right. And as you know, Mr. Hoyer, the President has convened a private sector group to join with him and with others to try to send this message: don't have a child before you're ready and able to take care of that child. We all need to reinforce those messages. And I absolutely agree with you about that.

Mr. HOYER. Thank you, Mr. Chairman.

Mr. MILLER. Thank you.

Mr. Riggs?

WISCONSIN WAIVER

Mr. RIGGS. Mr. Chairman, I know you want to move to the next panel. And I'm going to excuse myself momentarily. But I'd like to ask the Secretary before she leaves if, number one, she's received Wisconsin's waiver yet.

Ms. BANE. No.

Mr. RIGGS. Number two, well, even though you haven't received the waiver request yet, do you have an opinion regarding their program?

Ms. BANE. We have not in fact received the waiver request yet. I do know a little bit about it. It is designed to help welfare recipients make the transition to work. It is designed in a quite innovative way, as I understand it, to support them. When the waiver comes in, we're going to look at it very closely and work very hard with Wisconsin both to understand it and to see where we want to go with it.

Mr. MILLER. Do you have any more questions, Mr. Riggs?

Mr. RIGGS. No, thank you.

Mr. MILLER. Dr. Bane, thank you very much for being with us today. We appreciate your answering the questions. Thank you.

Ms. BANE. Thank you.

[Whereupon, at 3:11 p.m., the subcommittee proceeded to other business.]

[The following questions were submitted to be answered for the record:]

DEVELOPMENTAL DISABILITIES FUNDING

Mr. Porter: Your budget request for the Developmental Disabilities Act is \$121,850,000 an increase of about \$7 million over the FY 1996 conference agreement. What are the purposes of this funding, as you understand it? What are we trying to achieve?

Ms. Bane: The increase of \$7 million over the FY 1996 appropriation represents a return to the FY 1995 funding level. This level of funding will allow us to promote positive changes in state service system capacity for people with developmental disabilities, and will increase research and training in service delivery. We are hopeful that the funding will catalyze additional funding from State and local sources as well. The Administration strongly supports the FY 1995 funding levels for this program because at a time when Federal and State funding for traditional safety net programs is in such flux, programs such as these need to be poised to assist States and others to make new service delivery systems as responsive as possible to the complex and challenging needs of people with developmental disabilities and their families.

Mr. Porter: How do we know that these programs are successful? How do you measure performance in these programs? Do we simply say that these programs are supposed to be serving the disabled, therefore they must be worthwhile?

Ms. Bane: In order to better measure performance, the Administration for Children and Families is in the process of setting measurable targets for programs serving the developmentally disabled. Examples of measurable performance available at this time are:

- There has been an increase in the number of individuals with developmental disabilities living in community settings from 62,462 in June 1992 to 122,075 in June, 1994.
- Increasingly more children with developmental disabilities are living at home with their families and experiencing community living. More than 40 States now have Family Support legislation and programs to help families. Supports include respite care and personal assistance services.
- Every State now has efforts to include children with developmental and other disabilities into regular classrooms. These children and their families are becoming advocates and participants in the process of ensuring that each child, including those with significant disabilities receives a quality, appropriate education. ADD funded Youth Leadership activities to support young people with disabilities as they

become involved in their schools and communities and engage in activities with others that do not have disabilities.

Mr. Porter: Are these programs coordinated with the various other programs serving the disabled, such as special education and vocational rehabilitation? And if so, how is it done?

Ms. Bane: The programs funded by the Developmental Disabilities Assistance and Bill of Rights Act coordinate with other programs serving individuals with disabilities on an on-going basis. State Developmental Disabilities Councils include members from special education, vocational rehabilitation, and other State and local service providers. The Administration on Developmental Disabilities is also involved with the total disability community and the agencies that serve them including the Department of Labor, the Department of Education, and the Administration on Aging. For example:

- ADD and the Substance Abuse and Mental Health Services Administration, Protection and Advocacy for Individuals with Mental Illness Program are in the process of developing final rules for the Protection and Advocacy System which support the Developmental Disabilities Act and the Protection and Advocacy for Individuals with Mental Illness Act of 1986, as amended.
- ADD holds monthly meetings with representatives of offices administering various Protection and Advocacy programs (Developmental Disabilities, Mental Illness, Individual Rights, Assistive Technology, and Client Assistance Programs) to foster coordinated policy, guidelines, reports and reviews.

Mr. Porter: To what extent are these programs providing direct services to the disabled? Aren't we really providing funds for bureaucratic activities such as planning, coordinating, outreach and technical assistance, rather than direct services?

Ms. Bane: All of the ADD-funded programs provide direct and/or community-based services to persons with developmental disabilities. The Developmental Disabilities Councils sponsor innovative service demonstration projects. The Protection and Advocacy systems protect against abuse and neglect and ensure that people with developmental disabilities and their families receive appropriate legal representation. The University Affiliated Programs (UAPs) do research and training in cutting-edge disabilities service provision. The Projects of National Significance support advancements in the field of developmental disabilities by sponsoring research and demonstration projects in areas of overall national importance such as employment, personal assistance services, home ownership and criminal justice.

At one time the Councils were charged with a planning oriented mission, and were called "Planning Councils." That is no longer the case. Planning and coordination (or the strictly administrative or bureaucratic activities) of Council business is limited by law, and the Councils generally devote less than 21 percent of Council funding to those activities.

The UAPs, unique in their function of training professionals and paraprofessionals to provide direct services to people with developmental disabilities. The UAPs have shifted outdated paradigms from a focus on expert decision-making to consumer participation, from services provided in specialized environments to community-based services, and from specialized services to a holistic approach of support for individuals with disabilities.

TEEN PREGNANCY INITIATIVE PROGRAM

Mr. Porter: You are proposing to spend \$30 million in FY 1997 for a new Teen Pregnancy initiative. As we understand it, you plan to make 25 grant awards at \$1 million each and spend the remaining \$5 million for training and technical assistance, etc. How exactly do you plan to attack this social problem by spending \$30 million on it? How will this make a difference?

Ms. Bane: The teen pregnancy initiative builds on the Department's ongoing partnership with local communities. It will help communities with high rates of teen pregnancy and an appropriate infrastructure (from which to effectively launch and implement proposed strategies) to move their interventions to the next level of effectiveness. We intend to take what we have learned through a recent, exhaustive review of the research and the literature and use it to advance practice in the field.

A broad range of uses of the funds will be authorized with special priority on those that have been shown, through research, to have a positive effect on youth development and, therefore, on teenage pregnancy reduction.

The Department's work in the area of youth development and teenage pregnancy prevention to date confirms that in order to help communities move to a greater level of effectiveness in combatting teenage pregnancy, a significant infusion of resources is necessary.

Mr. Porter: Do you see this program as a time-limited effort of a few years' duration, or would it continue indefinitely under your planning?

Ms. Bane: While grantees may use their funds over a multi-year period, this initiative is not intended to continue indefinitely. Because the principal goal of the initiative is evaluation and learning, a specific end point -- after which we can assess what we have learned and determine next steps -- is important.

Mr. Porter: How would this proposed new program relate to the existing Adolescent Family Life program under the Public Health Service Act which the Administration is proposing to cut by \$1.5 million?

Ms. Bane: The Adolescent and Family Life (AFL) program is an abstinence-based program and therefore is limited in its ability to foster the comprehensive approaches research suggests are most promising. In addition, AFL is statutorily limited in the amount of money that can be dedicated to research. In contrast, evaluation and learning are the principal goals of the new initiative. While there are a variety of pregnancy prevention interventions in operation around the country, there is only preliminary data about their effectiveness. Through this new project we anticipate significantly expanding our knowledge about what works and what does not work in the area of teenage pregnancy prevention. This is why \$5 million of the \$30 million has been slated for a rigorous multi-site evaluation, training and technical assistance. Grantees will also use a portion of their funds for a process evaluation. Finally, successful applicants for this initiative must demonstrate a commitment to building on recently completed and reviewed research about promising approaches which indicate the importance of multi-faceted prevention and intervention strategies coordinated by the community.

Mr. Porter: Why should we start a brand new program when we already have one on the books that seems to have similar goals?

Ms. Bane: As I explained in the previous question, while there are other programs aimed at targeting teen pregnancy, this initiative fills a specific need -- to produce much needed learning and evaluation information about what is successful in this field.

REFUGEES

Mr. Porter: The 1995 and 1996 appropriations bills included language allowing the Office of Refugee Resettlement (ORR) to carry over unused funds from the previous year. The budget does not request continuation of this language. Why has this language been omitted from the request?

Ms. Bane: The 1995 and 1996 appropriation bills did include language allowing ORR to carry over unused funds from the previous year. While the Administration did not request continuation of this language in 1996, we did find the authority very useful because it provided flexibility to respond to the Cuban Migration Crisis.

Mr. Porter: This Committee has traditionally set aside funding for Florida communities impacted by Cuban and Haitian entrants. Do you believe this set-aside is justified, who have been the grantees, what amounts have they received, and should this practice be continued in 1997?

Ms. Bane: We have always followed Congress' guidance with respect to this set-aside and we would certainly continue to do so in the future. We also recognize the unique resettlement challenges States and communities have faced recently because of the increased entrant arrivals. States are the initial grantees of Targeted Assistance funds and until FY 1995, Florida, on behalf of Dade County subgrantees, was the sole recipient of this set-aside. The grantees for these funds have been:

FY 1986:	\$10,527,000 Jackson Memorial Hospital (JMH) and Dade County Public Schools (DCPS)
FY 1987:	No targeted assistance funds appropriated.
FY 1988:	\$10,531,000 Dade County for JMH and DCPS
FY 1989:	\$10,404,700 Dade County for JMH and DCPS
FY 1990:	\$14,000,000 Dade County for JMH and DCPS
FY 1991:	\$18,541,859 Dade County for JMH and DCPS
FY 1992:	\$19,000,000 Dade County for JMH and DCPS
FY 1993:	\$20,000,000 Dade County for JMH, DCPS, and Haitian community services.
FY 1994:	\$19,000,000 Dade County for JMH and DCPS
FY 1995:	\$19,000,000 Broward County, FLA (\$1,237,866), Dade County, FLA (\$15,431,234), Palm Beach County, FLA (\$1,622,223), and New York County, NY (includes Bronx, Kings, New York, Queens, and Richmond counties) (\$708,678).
FY 1996:	\$19,000,000 Proposed allocations to: Dade County, FLA (\$16,666,294), Palm Beach County, FLA (\$1,363,430), New York County, NY (\$500,469), and Bernalillo County, NM (\$469,807).

COMMUNITY SERVICES BLOCK GRANT

Mr. Porter: You propose to continue funding the Community Services Block Grant (CSBG) with no reductions, but you would eliminate all funding for related activities including community economic development, rural housing and community facilities and the National Youth Sports Program (NYSP). Are there other funding sources available to continue some of the small discretionary activities that you are proposing to terminate in FY 1997, such as the National Youth Sports and the community economic development program?

Ms. Bane: Grantees may use CSBG funds to support similar activities previously funded under separate Community Services Discretionary Programs. These eliminations reflect the concerns of the Congress to reduce the number of small categorical grant programs. It is not intended to take away program benefits from any particular group, but rather to address the budget deficit in a manner which consolidates these small categorical discretionary grant funds.

SOCIAL SERVICES BLOCK GRANT

Mr. Porter: The Administration proposes to continue funding the Social Services Block Grant at \$2.8 billion in FY 1997. However, Congress has just reduced funding in FY 1996 by 15 percent, down to \$2.38 billion. What is your assessment of the impact on services of cutting SSBG funding by 15 percent, especially more than half way into the fiscal year?

Ms. Bane: The Administration is very concerned about the impact of these cuts on low and moderate income individuals and their families. The number of continuing resolutions, resulting in the starting and stopping of state funding, has been very difficult. We are taking every measure we can to provide States with the most flexibility in allocating this reduction. However, the 15 percent cut in the Social Services Block Grant this late in the fiscal year is creating problems. Most States have purchase of social service contracts in place with public and private provider agencies and the 15 percent cut will require immediate cuts in funding of these contracts. This means a cutback in social services being provided by these agencies.

Mr. Porter: Are you planning to reassess your 1997 budget request in light of the Congressional action for 1996?

Ms. Bane: No plans are being made to reassess our 1997 budget request.

FAMILY VIOLENCE

Mr. Porter: The Family Violence Prevention and Services Act authorizes a variety of services, including funds for battered women's shelters for victims of domestic violence and their dependents. A national toll-free 24-hour telephone hotline, also authorized under the Act, became operational on Feb. 20, 1996. Since the telephone hotline began operating, what volume and type of calls have been received?

Ms. Bane: Between February 21 and April 17, hotline staff responded to 13,509 calls. Nearly half of these calls (44%) were from victims of domestic violence; about 15% were from family members or friends and about 9% were from advocates or service providers.

Mr. Porter: How is the public being made aware of the hotline?

Ms. Bane: All of the major network and national morning shows covered the hotline opening and announced the telephone number (1-800-799-SAFE). Public Service Announcements on NBC aired numerous times throughout the month. The following television shows featured the hotline's number: The Oprah Winfrey Show, The Leeza Gibbons Show, The Rolanda Show, Show de Cristina, and NBC's Real Life. The number also appeared frequently on MTV. Over 80% of callers say they heard about the hotline on television. During the first month of operations, radio interviews were aired in: San Diego, San Francisco, Los Angeles, Chicago, and the States of Massachusetts, Arkansas, Texas, and Maryland. Information about the hotline also aired on the Wake Up America and Ivanhoe Broadcasting syndicated systems.

Mr. Porter: Given the very close relationship between domestic violence and child abuse, how do you coordinate Department activities and programs in these two areas?

Ms. Bane: Departmental activities and programs are coordinated in several ways: through participation by the appropriate program offices and bureaus in the activities of the Departmental Steering Committee for the Implementation of the Violence Against Women Act; by collaborating in the exchange of information among their clearinghouses and resource centers; and by their joint support of collaborating grantees.

Mr. Porter: How do services provided under the Family Violence Act differ from activities now authorized under the Violence Against Women Act? Are services under these two acts coordinated with each other?

Ms. Bane: The Family Violence Prevention and Services Act has provided support for State shelter grants, resource centers, domestic violence coalitions, and public information activities; the Violence Against Women Act amended the Family Violence Prevention and Services Act to expand the support for shelters, established the national hotline, provided grants to reduce sexual abuse of

runaways, and required the selection of model projects that provide violence prevention education to our youth. These services are coordinated through the Departmental Steering Committee and staff work group, and the ongoing collaboration of program staff, clearinghouses, and resource centers.

Mr. Porter: How do HHS and the Department of Justice work together in the area of domestic violence?

Ms. Bane: HHS and the Department of Justice have a long history of working together in the area of domestic violence. The collaborative efforts are most visible in the leadership of the Advisory Council on Violence Against Women which is co-chaired by the Attorney General and the Secretary of HHS. Departmental and program staff continually cooperate through joint participation on work groups, steering committees, conference presentations; providing comments on proposed rules and program announcements; and, through numerous interagency agreements.

COMMUNITY-BASED RESOURCE CENTERS

Mr. Porter: What are the main purposes of the community-based resource center program?

Ms. Bane: The purpose of the Community-Based Family Resource Program is to assist States to develop and implement, or expand and enhance, a comprehensive, statewide system of community-based family resource services through innovative funding mechanisms and collaboration with existing education, vocational rehabilitation, health, mental health, employment and training, child welfare, and other social services agencies within the State. Funds are used to ensure family involvement in the design and operation of programs that are responsive to the unique and diverse strengths of children and families. A further purpose of the program is to expand collaboration at the State and community levels, both among government agencies and between public and private entities, in order to foster a continuum of preventive services for children and families.

Mr. Porter: Why are you proposing to increase this from \$23 million in 1996 to \$50 million in 1997?

Ms. Bane: The Community-Based Family Resource Program (CBFRP) was authorized by Congress in the Human Services Amendments of 1994. It was created by consolidating several smaller programs focused on child abuse prevention and family resource and support services. The consolidation of these programs reflected a desire on the part of Congress to provide States and communities with a flexible funding source that could be used to support a variety of preventive and support services that best met the needs of families in individual communities.

Funding for CBFPR was set at \$31.4 million in FY 1995, the first year that the consolidated program received funds. The FY 1996 appropriation of \$23 million represented a cut in the program. For FY 1997, the Administration proposes to consolidate two additional programs with related purposes into the CBFPR, the Temporary Child Care and Crisis Nurseries program and the McKinney Act Family Support Center program, and to restore funding to the FY 1995 level. The requested FY 1997 funding level of \$50 million reflects the combined funding levels for the three programs in FY 1995.

Mr. Porter: Why shouldn't the States fund these activities themselves without a Federal subsidy?

Ms. Bane: In tight fiscal times, when the numbers of abused and neglected children continue to grow, when the number of children in foster care remains high, and when the problems faced by families seem ever more complex and difficult, the risk of all available funds being dedicated to crisis-oriented services increases. While the need for services to children and families in crisis remains great, it is also important that we continue to invest in the kinds of supportive services that can strengthen families and communities and prevent them from needing more serious crisis intervention services.

The Community-Based Family Resource Program builds on the foundation of the "Challenge Grant" legislation of 1986 which challenged States to establish children's trust funds dedicated to the prevention of child abuse and neglect. The Family Support Centers also were a part of the foundation of this program. The Support Centers provided intensive and comprehensive supportive services to enhance the physical, social and educational development of low-income individuals and families. A key element of this legislation was the idea that Federal funds would be used as a catalyst to leverage greater investment on the part of States, communities and private organizations in prevention activities. The current program recognizes the important role that a broad range of community-based family services can play in helping families raise healthy children. Eliminating Federal funding at this point would set back 10 years of bipartisan support for the development of infrastructures in all States that are dedicated to supporting families before they go into crisis and risk harming their children.

ADMINISTRATIVE COSTS

Mr. Porter: You're proposing to increase your administrative budget by \$10 million in 1997, from \$150 million to \$160 million. This is nearly a 7 percent increase. Why is it necessary to do this?

Ms. Bane: The FY 1997 budget request for Federal Administration of \$160,279,000 is a net increase of \$10,162,000 (+6.7%) over FY 1996 funding levels. However, the request merely attempts to bring funding levels for FY 1997

back in line with funding levels of recent years, thereby allowing ACF to maintain the staff and related essential programmatic support activities which are necessary for it to continue the President's important children and family initiatives.

In FY 1997, projected FTE usage of 1,768 will again remain under ACF's ceiling of 1,803. The additional \$10.2 million requested for Federal Administration in FY 1997 will support ACF's full-time equivalent positions and related expenses. Key uses of these additional funds will include payment of built-in increases, including the costs of the FY 1997 pay raise (approximately \$5.7 million) and provision of additional travel funding for technical assistance and monitoring (approximately \$1.3 million).

ACF also needs this increase to continue its effort to invest in information systems and related technology which have to date allowed its diminished workforce to handle workload demands which continue in the aggregate to grow. This includes investment in ADP (\$1.1 million) and equipment costs and consolidation (approximately \$1 million more). These latter investments were originally scheduled to take place in FY 96, but had to be deferred due to insufficient funding. The development of information systems -- ours and grantees' -- are ultimately expected to increase productivity.

Finally, these additional funds requested for FY 1997 will also allow ACF to cover increases in the costs of mandatory non-pay activities; without these funds ACF's ability to provide effective, efficient stewardship of the \$33.8 billion in Federal funds entrusted to it for FY 1997 will be jeopardized. Thus a portion of the increase will be provided for higher core costs including rent, telecommunications, and contractual obligations. Extensive efforts will continue to contain these costs, since increases limit funds available for other key functions such as travel to monitor implementation of ACF programs, training and technical assistance.

Mr. Porter: Your administrative budget went down considerably from FY 1995 to 1996. Why not keep it at the lower level?

Ms. Bane: Our administrative budget was artificially forced down between FY 1995 and FY 1996 by a sharp reduction in our appropriated funds. The current funding level is neither normal nor desirable if the agency is to carry out its mission effectively and efficiently. ACF's workload during this period has not diminished. While a few of our programs have been sharply reduced or eliminated, these have been small programs which continue to generate work in the form of grant close-out.

ACF has tried with some success to offset those reductions in FY 1996 through increasing productivity, especially by automation, re-engineering key processes, and reducing overhead positions.

However, reduced funding has also necessitated a near-total freeze on hiring, elimination of performance awards, elimination of all but core staff and overhead expenditures, and delays in technological investments in information systems that are intended to allow our shrinking work force to be more productive with fewer resources. Such negative changes, maintained over the long run, will only further erode our ability to monitor and effectively oversee the almost \$34 billion in funding entrusted to us.

Mr. Porter: How many employees do you currently have on board, and how does that compare with the end of FY 1995?

Ms. Bane: At the end of FY 1995, ACF had 1,816 staff on board; currently, we have 1,753 staff on-board, a reduction of 63 on-board staff. To make these numbers comparable, I've added to the FY 1995 number 19 staff who came to us at the beginning of FY 1996 as a result of HHS' devolving certain personnel functions to HHS operating components. (Neither the FY 1995 nor the FY 1996 on-board levels reflect individuals serving on one of the three ACF advisory boards and commissions. At the end of FY 1995, there were a total of 48 such individuals.)

Mr. Porter: Are you planning to increase your employment level between now and the end of FY 1997? If so, by how much?

Ms. Bane: We have requested sufficient funds to increase employment levels by 9 FTE. This modest staff increase will help to offset staff reductions of recent years. By making these small increases, and by continuing to invest in information systems and other technologies which generate greater productivity from its shrinking work force, ACF will be able to maintain the initiatives which are key to its mission.

This small increase will not, however, change ACF's commitment to carefully manage its Federal Administration resources. Over the last two years, ACF has moved to downsize, streamline and consolidate its personnel and related activities. Its FTE ceiling for FY 1996 has been reduced from 2,009, established in FY 1995, to its current ceiling of 1,803 FTE. ACF has also aggressively moved to reduce actual FTE usage, which has dropped from 1,965 in FY 1994 to the current estimate for FY 1996 of 1,759 FTE. Further, the 1,759 FTE is expected to be achieved despite the devolution to ACF of 23 FTE from the Office of the Secretary in connection with the decentralization of personnel servicing operations.

CHILD CARE PROGRAMS

Mr. Porter: Describe for the Committee the Administration's proposal for child care as a component of welfare reform. Specifically, how much total funding are you proposing for child care and how does this amount compare with current funding levels, the level contained in the vetoed Reconciliation Bill, and the amount recommended by the National Governors Association (NGA).

Ms. Bane: The Administration proposal guarantees child care for families participating in activities to help them move from welfare to work, and for one year for families who lose welfare eligibility by obtaining a job. The bill increases authorization levels for child care assistance to the working poor. It maintains critical health and safety standards, and investments in quality improvement and supply building.

The Administration proposal authorizes discretionary appropriations of \$2 billion for FY 1996, and such sums as may be necessary for FYs 1997-2002. \$12.2 billion in entitlement matching funds to states would be authorized for FYs 1997-2002. All entitlement child care funds would be matched at the Medicaid rate. This is an increase in mandatory child care funding over current law of \$2.6 billion over 6 years (April 1996 CBO baseline).

The Conference Agreement authorizes a total of \$7 billion in discretionary funding for FYs 1996-2002. \$10 billion in entitlement matching funds to states would be authorized for FYs 1997-2002.

The NGA proposal authorizes a total of \$7 billion in discretionary funding for FYs 1997-2002 and \$14 billion in mandatory funding for FYs 1997-2002.

Mr. Porter: What child care data do you currently collect? For example, what can you tell us about the number of children and families who receive Federal child care assistance? And what percentage of child care is paid for by the Federal government?

Ms. Bane: The Child Care and Development Block Grant legislation and regulations require grantees to collect information regarding the uses of grantee funds. Each year grantees complete a two page form which provides the following information:

- Number of families served
- Number of children served annually, by age, type of child care provider, reason for needing care, and income level
- Use of payment mechanisms
- Average number of hours of care provided per child per week, by type of provider and age of child

- Average hourly amount paid for child care, by type of provider and age of child
- Expenditures by types of grantee services (child care subsidies, administration, before and after school/early childhood development programs, and quality activities) and fiscal spending period

Title IV-A Child Care (AFDC/JOBS, TCC, ARCC) programs collect information through a variety of forms on the following:

- Average monthly number of children served (this is not annualized) by program, age, type of provider, and parental eligibility status
- Average monthly expenditures (federal and grantee match), by program
- Average monthly child care payment, by type of provider and age of child
- Average number of months of child care assistance

In 1993, it was reported that Block Grant funds purchased services (in part or in full) for 755,094 children. Title IV-A grantees reported serving an average of 642,977 children per month during 1993.

Currently, 1994 data are being analyzed, and 1995 data are being collected.

We do not know what percentage of child care is paid for by the Federal government. However, we can calculate a very rough estimate using Census data. The Bureau of Census reported that families spent at least \$23.6 billion on child care in 1991. ACF subsidizes approximately \$2 billion in child care through the CCDBG and IV-A child care programs. Our subsidies compose less than 10% of the paid child care total. Another important Federal support for child care is the dependent care tax credit, which allowed parents to file \$2.5 billion of tax credits for child care expenses in 1991.

Mr. Porter: How do you measure the need for child care services? Are anecdotal reports of waiting lists in certain States reliable indicators of the actual need? Please comment on what you consider to be the areas with the greatest need?

Ms. Bane: The issue of access to affordable care is critical. Twenty-one million children meet the income eligibility requirements for CCDBG. Thirty-seven percent (37%) of these children, approximately 8 million children, live in families with a single parent who is working or a two parent family where both parents work. Many more of these children live in families who want to work or who are in education and training programs. Federal child care subsidies are available to serve only a small fraction of these children. The resulting waiting lists across the country tell the story of numerous families who are unable to work because of lack of child care. Long waiting lists are consistently reported in

studies, testimony, letters to the Department, etc. Clearly the exact shape of waiting lists changes from day to day, and we do not have a systematic method to receive and update these numbers. However, I do believe that local authorities recognize their waiting lists as genuine indicators of the need for child care subsidies in their localities.

The Child Care and Development Block Grant Act has three goals, to improve the availability, affordability and quality of child care services. In measuring need, it is important to look at all three goals. Many communities are faced with an inadequate supply of child care; they can measure this by comparing the number of available slots to the number of children with parents who are working or in school. We know, from reports by the GAO, Urban Institute, and others that areas of greatest need for an increased supply of care include infant/toddler care, school-age care, care during non-traditional hours, and care in poor urban and rural communities.

The General Accounting Office noted lengthy waiting lists for working poor families in its May 1994 report to the Committee on Education and Labor. Five out of six sites they visited had waiting lists.

Mr. Porter: In May 1994, HHS proposed regulations that were intended to improve the functioning of the four major child care programs and to promote greater coordination among them. Comments were due in July 1994, but final regulations have not been published.

Ms. Bane: Based on the comments we received on the proposed rule, we prepared final regulations that promote greater coordination among the four major child care programs and support safe and healthy child care. However, the Secretary has remained hopeful that Congress will pass bipartisan welfare reform legislation, including important changes to existing child care programs.

Mr. Porter: Do you intend to issue final regulations based on your May 1994 proposal? If so, when will these rules be published?

Ms. Bane: The decision on when to issue the final rule is still under consideration pending the outcome of the welfare reform legislation.

Mr. Porter: Under current law, 25 percent of child care block grant funds are reserved for activities to improve and promote quality in child care and to expand certain types of services. Tell us how States have used their quality set-aside funds so far.

Ms. Bane: The CCDBG statute requires States to reserve 25 percent of their awards for activities to improve the quality of child care and to increase the availability of early childhood development and before- and after-school care services. States may also use up to 15 percent of their 75 percent funds for administration and activities to improve the quality and availability of child care.

Total expenditures on quality under both the 75 and 25 percent funds for the 1993 reporting period totaled \$66,470,571. Of those funds the following percentages by service type were reported by grantees:

○ Child Care Resource and Referral	30%
○ Monitoring and Licensing of Providers	29%
○ Training and Technical Assistance	23%
○ Improvement of Standards	13%
○ Other Authorized Activities	5%
○ Improving Staff Compensation	1%

Mr. Porter: On page 14 of the child care justification you indicate that you are spending \$2,323,000 on a training and technical assistance contract. What is the purpose of this contract?

Ms. Bane: Section 658I(a)(3) of the statute provides authority for the Secretary to provide technical assistance to grantees. By regulation, technical assistance funds are limited to one quarter of one percent for any fiscal year of Child Care and Development Block Grant funding. The purpose of the contract is to assist States in the implementation and administration of their child care systems.

The Department is advised by a group of State and Tribal child care administrators regarding responses to the technical assistance needs of grantees and the quality of performance by contractors. This effort has substantially improved the level of communication among grantees and with the Department.

Among the activities provided by the contract are:

- National Child Care Information Clearinghouse, an adjunct ERIC Clearinghouse with on-line and other resources for child care grantees
- National training and information resource meetings for grantees
- National leadership forums on topics such as health and safety, infant child care, school-age child care, family centered child care, children with disabilities in child care settings, and child care policy research
- Administrative and Programmatic Issues meetings at national and regional levels
- On-site technical assistance to States and Tribes on administrative and programmatic issues
- Child Care Bulletin, published 6 times per year

Mr. Porter: What period of time does the contract cover?

Ms. Bane: The current contract period covers an initial 18 month period, which began in October 1994, with two one-year options. The contract will end in March of 1998.

Mr. Porter: Was the contractor selected in a competition or was it a sole-source selection?

Ms. Bane: The contractor was selected through a competitive process among minority/disadvantaged small business (8A) contractors. Three companies submitted proposals.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

Mr. Porter: Ms. Bane, supporters of the LIHEAP program often present this subcommittee with information regarding the income of LIHEAP recipients. However, this information does not tell the full story because it generally omits non-cash governmental assistance such as food stamps and subsidized housing. I have asked ACF for information on LIHEAP recipient income including non-cash assistance, and the agency has been unable to provide such data. Are you able to provide that data for us this year? [If so, please submit for the record.]

Ms. Bane: We do not collect information from LIHEAP grantees about the sources of income of LIHEAP recipients. However, we estimate from data from the Census Bureau's March 1995 Current Population Survey that 76 percent of the households receiving heating assistance during the 1994-95 winter also received one or more of these: public assistance through AFDC; Food Stamps; SSI; subsidized housing or other public assistance. Estimates of receipt of other assistance are unavailable for LIHEAP cooling, crisis, or weatherization assistance.

Income data that we use for our calculations comes from the March Current Population Survey conducted by the Census Bureau. As defined by the Census Bureau, income includes cash assistance received by a household, such as AFDC and SSI. It does not include estimates of the value of non-cash income, including non-cash assistance, such as food stamps or subsidized housing.

Accordingly, we are not able to provide calculations based on non-cash assistance.

Mr. Porter: The Low Income Home Energy Assistance Act now allows states to determine the types of payments it makes for LIHEAP including unrestricted cash payments to vendors or energy vouchers. Would you tell us roughly how total LIHEAP funding is allocated by the States among these three payment types, and would you provide the specifics for the record?

Ms. Bane: We do not collect systematic information from LIHEAP grantees about the types of payments made to LIHEAP recipients or the amounts distributed under each method. However, we estimate from data from the Department of Energy's 1990 Residential Energy Consumption Survey that of the households receiving heating assistance during federal fiscal year 1990, the following methods were used:

<u>Payment Type</u>	<u>% of Recipients</u>	<u>% of Dollars</u>
Check to Fuel Supplier	65%	58%
Check to Household	9%	21%
Voucher	3%	4%
Two-Party Check	12%	14%
Other	2%	3%

We do not have updated estimates from the 1993 Residential Energy Consumption Survey at this time.

We know of no State that uses unrestricted payments to households as its primary method of distributing benefits. Most States make direct cash payments to clients only in very limited circumstances, if at all.

By far, the most common method of payment is a letter of credit to a recipient household's heating vendor. The vendor receives payment only upon providing documentation that the benefit has been used to pay for home energy for the household. Some States provide vouchers or two-party checks, usually in cases where the household's energy vendor has refused to sign a vendor agreement that provides the assurances of equitable treatment required by the law.

Mr. Porter: Ms. Bane, the 1995 budget request for LIHEAP indicated that recent expansion in the Earned Income Tax Credit and the Food Stamps program had lessened the need to continue providing LIHEAP at historic levels. Would you please submit for the record an analysis of how that legislation and other recent legislation impacting LIHEAP recipient income has improved recipient self-sufficiency.

Ms. Bane: We do not have any current data on the value of Earned Income Tax Credits (EITC) or food stamps received by households eligible for LIHEAP. We do not collect information from LIHEAP grantees about the sources of income of LIHEAP recipients. Income data that we use for our calculations comes from the March Current Population Survey conducted by the Census Bureau. As defined by the Census Bureau, income data is calculated before taxes (and thus does not include EITC) and includes cash assistance received by a household, such as AFDC and SSI. It does not include estimates of the value of non-cash income, including non-cash assistance, such as food stamps or subsidized housing.

Based on simulation data from the Urban Institute's TRIM2 model combined with data from the March 1992 Current Population Survey, we estimated that 37 percent of the LIHEAP recipient households in 1992 would have been eligible to receive EITC under the 1996 rules. These households would have been eligible to receive \$1.8 billion in EITC benefits and that 63% of the LIHEAP recipient households would not have been eligible for EITC. Many of the LIHEAP recipient households may only be eligible for small EITC payments earmarked for families with children.

Mr. Porter: Please submit for the record a table indicating the number of LIHEAP recipients that pay no energy bill, receive other energy assistance and the amount of that assistance, and the number of recipients who make fixed energy payments. In each case, indicate the amount of LIHEAP funding received by these recipients.

Ms. Bane: We do not have any data on the number of LIHEAP recipients that receive other energy assistance or who make fixed payments for their energy consumption.

Mr. Porter: Are any oil overcharge funds available for either 1996 or 1997, and if so, in what amounts?

Ms. Bane: According to staff in the Department of Energy, there are no significant oil overcharge distributions expected to be made in the future, including for 1996 or 1997. There are some very minor cases that will net very small amounts of money to only certain States in the next few years, but none of those funds will be authorized for use in LIHEAP.

Mr. Porter: Please provide a table indicating fuel consumption, fuel expenditures and energy burden by fuel type for all households, low income households and LIHEAP recipient households for 1980-1995. For the purposes of this table, the income measurement used to calculate energy burden should include the value of all federal, state and local assistance. It is not necessary to repeat information from the Annual Report to Congress if such information does not include non-cash income and non-cash assistance such as food stamps or subsidized housing.

Ms. Bane: The income measurement to calculate energy burden does not include non-cash income and non-cash assistance such as food stamps or subsidized housing. We are unable to provide calculations based on non-cash assistance.

Mr. Porter: Please submit for the record the amount of funding by State carried over from FY 95 - FY 96.

Ms. Bane: Attached is a listed showing the estimated carryover of FY 1995 LIHEAP funds to FY 1996, by state.

<u>State</u>	<u>Carryover to FY 1996</u>
Alabama	750,763
Alaska	425,764
Arizona	-0-
Arkansas	85,000
California	5,895,123
Colorado	-0-
Connecticut	2,883,828
Delaware	363,057
Dist. of Col.	233,502
Florida	-0-
Georgia	262,320
Hawaii	13,938
Idaho	96,363
Illinois	4,000,000
Indiana	-0-
Iowa	1,629,663
Kansas	954,843
Kentucky	-0-
Louisiana	-0-
Maine	1,319,198
Maryland	1,870,881
Massachusetts	5,224,770
Michigan	7,965,588
Minnesota	3,765,292
Mississippi	200,000
Missouri	2,307,942
Montana	227,511
Nebraska	1,100,000
Nevada	180,979
New Hampshire	1,100,888
New Jersey	1,500,000
New Mexico	44,538
New York	15,900,000
North Carolina	-0-
North Dakota	814,725
Ohio	1,570,305
Oklahoma	156,430
Oregon	72,470
Pennsylvania	7,825,423
Rhode Island	108,984
South Carolina	325,748
South Dakota	261,815
Tennessee	559,811

<u>State</u>	<u>Carryover to FY 1996</u>
Texas	-0-
Utah	888,974
Vermont	336,645
Virginia	2,431,277
Washington	300,000
West Virginia	790,851
Wisconsin	3,000,000
Wyoming	289,118
Total	\$80,034,327

Mr. Porter: According to the most recent available information, please provide the tables relating to LIHEAP that were printed in the FY 96 hearing volume (pp.837-863).

Ms. Bane: Information is attached showing prices adjusted for inflation (using FY 1995 dollars) for the three major heating fuels - natural gas, electricity, and fuel oil - as well as for a composite average.

Table 2. Average price by fuel type and by year, constant FY 1995 dollars per millions of British Thermal Units¹

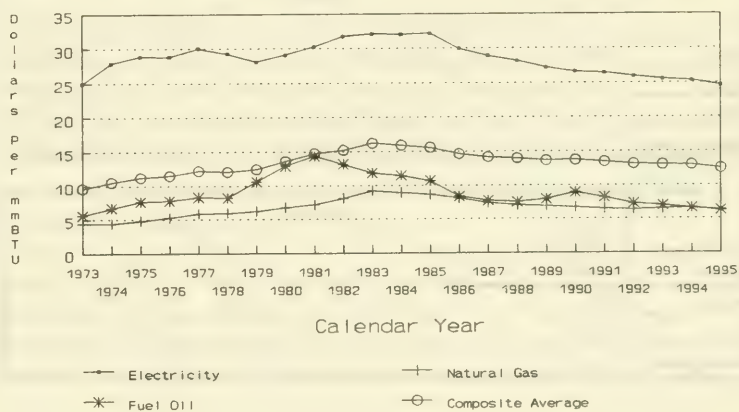
Fuel Type	Calendar Year										
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Electricity	24.98	27.90	28.87	28.86	30.02	29.28	28.11	29.08	30.27	31.73	32.08
Natural Gas	4.40	4.39	4.81	5.27	5.87	5.94	6.21	6.76	7.15	8.11	9.21
Fuel Oil	5.61	6.70	7.95	7.79	8.29	8.20	10.59	12.80	14.34	13.12	11.82
Composite Average	8.82	10.55	11.22	11.49	12.21	12.05	12.43	13.59	14.75	16.22	16.23

Fuel Type	Calendar Year										
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
Electricity	32.03	32.17	29.96	28.90	28.18	27.20	26.62	26.43	25.95	25.51	25.32
Natural Gas	8.82	8.61	8.05	7.38	7.01	6.88	6.72	6.48	6.34	6.46	6.59
Fuel Oil	11.46	10.88	8.33	7.72	7.51	7.92	8.91	8.17	7.27	6.93	6.68
Composite Average	15.93	15.59	14.64	14.18	13.97	13.84	13.71	13.45	13.11	13.01	12.98

Fuel Type	Calendar Year										
	FY 95										
Electricity	24.82										
Natural Gas	6.21										
Fuel Oil	6.24										
Composite Average	12.49										

¹Composite (all fuels) average is weighted, based on the amount of each fuel (i.e., electricity, natural gas, and fuel oil) purchased for residential use. Fuel prices were taken from tables 9.8, 9.9, and 9.11 of the Monthly Energy Review (December 1995, DOE/EIA-0035 (95/12)). Fuel costs were converted to dollars per mmbtu using conversion factors shown in tables A.2, A.5, and A.9 of the same issue of the Monthly Energy Review.

Average Fuel Prices In Constant Dollars



NUMBER OF HOUSEHOLDS ASSISTED BY STATES¹

	HEATING	COOLING	YEAR ROUND CRISIS	WINTER SUMMER CRISIS	WEATHERIZATION
1984	6,443,637	537,598	992,774 (combined win/sum)	180,758	
1985	6,545,616	511,333	885,005 (combined win/sum)	217,864	
1986	6,359,924	535,553	951,945	114,194	191,316
1987	6,495,409	366,721	1,060,425	60,797	172,372
1988	5,827,481	309,044	981,775	57,750	156,770
1989	5,595,268	126,977	890,616	20,384	142,584
1990	5,459,631	358,823	1,058,067	37,340	148,104
1991	5,769,346	374,483	1,004,634	39,399	127,587
1992	5,906,292	384,468	950,275	25,570	106,066
1993	5,282,993	143,279	956,435	47,169	111,295
1994	5,663,040	145,684	1,127,832	24,532	126,086
1995*	5,208,597	378,790	907,582	36,734	127,905

*Estimate

AVERAGE BENEFIT LEVEL¹

	HEATING	COOLING	YEAR ROUND CRISIS	WINTER SUMMER CRISIS	WEATHERIZATION ²
1984	213	60	227 (combined win/sum)		NA
1985	224	57	216 (combined win/sum)		NA
1986	213	67	208 (combined win/sum)		NA
1987	197	81	189 (combined win/sum)		NA
1988	197	68	198 (combined win/sum)		NA
1989	182	97	208	95	NA
1990	189	70	175	109	NA
1991	190	73	216	105	NA
1992	168	59	204	137	NA
1993	180	155	187	97	NA
1994	188	171	198	95	NA

¹ A total unduplicated number of LIHEAP recipient households cannot be calculated from state reports because households could receive more than one type of LIHEAP assistance.

¹ Computed by HHS based on state estimates of obligated funds and state reports on number of households assisted.

² Comparable data are not available.

Mr. Porter: Please provide a table for the record which indicates the average resources in constant dollars available to LIHEAP recipients from all sources including income, and federal, state and local assistance 1979-1994.

Ms. Bane: Information showing constant dollar income available for LIHEAP recipients for the years 1981-1992 is attached.

Income data that we use for our calculations comes from the March Current Population Survey conducted by the Census Bureau. As defined by the Census Bureau, income includes cash assistance received by a household, such as AFDC and SSI. It does not include estimates of the value of non-cash income, including non-cash assistance, such as food stamps or subsidized housing. Accordingly, this table is valid as it relates to cash income and cash assistance. We are not able to provide calculations based on non-cash assistance.

Average LIHEAP recipient household cash income from March Current Population Surveys in 1981 constant dollars, calendar years 1981 - 1994

<u>Calendar Year</u>	<u>1981 Constant Dollars</u>
1981	\$7,215
1982	\$6,690
1983	\$6,709
1984	\$6,921
1985	\$6,623
1986	\$6,812
1987	\$6,568
1988	\$6,383
1989	\$6,551
1990	\$6,526
1991	\$6,366
1992	\$6,310
1993	\$7,164*
1994	\$7,287*

* Data for FY 1993 and 1994 may not be comparable to earlier data due to changes in CPS interview methodology. Caution should be used in interpreting the data for 1993 and 1994.

Percent of household income spent on residential, space heating, and space cooling energy by all, low income, and LIHEAP recipient households*

<u>Fiscal</u> <u>year</u>	<u>Total Residential</u>			<u>Space Heating</u>			<u>Space Cooling</u>		
	<u>All</u>	<u>LoIn</u>	<u>LIHEAP</u>	<u>All</u>	<u>LoIn</u>	<u>LIHEAP</u>	<u>All</u>	<u>LoIn</u>	<u>LIHEAP</u>
1982	4.5	10.7	13.3	-	-	6.8	-	-	-
1983	4.3	14.1	16.1	1.6	5.8	7.0	-	-	-
1984	4.4	13.9	-	1.7	5.9	-	-	-	-
1985	4.1	13.4	15.6	1.6	5.4	6.6	-	-	-
1986	3.9	12.9	15.1	1.4	5.1	6.2	0.4	1.1	1.0
1987	3.4	11.4	13.2	1.2	4.2	5.2	0.4	1.0	1.4
1988	3.4	10.6	13.8	1.2	3.9	5.4	0.4	1.2	1.3
1989	3.3	10.8	13.7	1.1	3.9	5.4	0.4	1.1	1.1
1990	3.1	10.3	13.2	1.1	3.7	5.2	0.4	1.1	1.1
1991	3.2	10.1	12.4	1.0	3.3	4.7	0.4	1.1	0.2
1992	3.1	9.6	11.5	1.0	3.2	4.4	0.4	0.9	0.9
1993	3.3	9.7	12.1	0.1	3.3	4.7	0.4	0.9	1.0
1994	3.3	9.8	12.1	0.0	3.3	4.5	0.4	0.9	0.9

- indicates that data are unavailable.

*As reported in HHS' annual LIHEAP reports to Congress

FY 1994 LIHEAP administrative costs as a percentage of available federal funds, by State

<u>State</u>	<u>Fund payable</u>	<u>Administrative costs</u>	<u>Admin. costs/ funds payable</u>
Total	\$1,735,574,464	\$148,367,568	8.5%
Alabama	12,481,184	1,106,037	8.9%
Alaska	6,509,737	650,974	10.0%
Arizona	5,850,686	585,069	10.0%
Arkansas	9,280,767	909,609	9.8%
California	67,236,819	6,697,794	10.0%
Colorado	23,034,789	2,280,593	9.9%
Connecticut	37,765,205	3,345,691	8.9%
Delaware	4,329,035	376,142	8.7%
Dist. of Col.	4,898,046	447,298	9.1%
Florida	19,173,438	1,917,343	10.0%
Georgia	16,225,478	1,289,533	7.9%
Hawaii	1,527,801	152,780	10.0%
Idaho	8,834,804	878,488	9.9%
Illinois	94,011,051	8,191,488	8.7%
Indiana	43,377,969	4,197,453	9.7%
Iowa	34,350,638	2,918,489	8.5%
Kansas	12,453,662	1,205,343	9.7%
Kentucky	31,061,921	2,491,105	8.0%
Louisiana	12,390,034	1,228,622	9.9%
Maine	26,617,234	2,475,053	9.3%
Maryland	30,288,356	2,980,318	9.8%
Massachusetts	76,142,137	6,737,597	8.8%
Michigan	126,360,604	7,726,348	6.1%
Minnesota	93,566,514	8,476,401	9.1%
Mississippi	10,402,813	1,038,539	10.0%
Missouri	32,781,183	3,264,875	10.0%
Montana	9,066,649	814,616	9.0%
Nebraska	12,997,004	1,299,700	10.0%
Nevada	2,983,515	296,465	9.9%
New Hampshire	14,393,450	1,304,866	9.1%
New Jersey	65,103,737	6,149,674	9.4%
New Mexico	6,786,674	614,008	9.0%
New York	244,443,690	22,210,280	9.1%
North Carolina	26,283,392	3,074,630	11.7%
North Dakota	16,719,438	1,050,703	6.3%
Ohio	97,058,234	5,169,927	5.3%
Oklahoma	10,396,504	858,370	8.3%
Oregon	17,811,868	1,863,419	10.5%
Pennsylvania	119,236,923	8,767,367	7.4%
Rhode Island	12,491,845	1,130,000	9.0%
South Carolina	10,168,354	1,025,447	10.1%
South Dakota	9,501,433	736,244	7.7%
Tennessee	19,582,328	301,596	1.5%
Texas	32,003,457	3,192,226	10.0%
Utah	10,358,532	757,246	7.3%
Vermont	13,776,533	1,319,640	9.6%
Virginia	28,331,836	2,795,840	9.9%
Washington	28,429,040	2,706,984	9.5%
West Virginia	16,503,089	1,650,308	10.0%
Wisconsin	65,974,733	5,287,000	8.0%
Wyoming	4,220,301	422,030	10.0%

FY 1995 LIHEAP administrative costs as a percentage of available federal funds, by State

<u>State</u>	<u>Fund payable</u>	<u>Administrative costs</u>	<u>Admin. costs/ funds payable</u>
Total	\$1,410,444,736	\$132,979,181	9.4%
Alabama	11,362,854	976,668	8.6%
Alaska	5,489,619	583,778	10.6%
Arizona	5,292,549	625,135	11.8%
Arkansas	8,466,795	800,000	9.4%
California	61,373,585	6,137,359	10.0%
Colorado	21,371,460	2,069,406	9.7%
Connecticut	28,507,455	3,248,031	11.4%
Delaware	3,630,571	363,057	10.0%
Dist. of Col.	4,401,982	421,952	9.6%
Florida	17,508,317	1,749,385	10.0%
Georgia	13,840,792	1,176,467	8.5%
Hawaii	1,393,844	139,384	10.0%
Idaho	8,007,198	804,464	10.0%
Illinois	90,445,449	7,472,663	8.3%
Indiana	45,871,109	4,182,054	9.1%
Iowa	28,590,501	2,429,609	8.5%
Kansas	10,996,187	1,099,618	10.0%
Kentucky	23,041,270	2,299,623	10.0%
Louisiana	11,301,713	1,140,553	10.1%
Maine	17,123,135	1,700,000	9.9%
Maryland	22,154,416	2,619,935	11.8%
Massachusetts	61,441,777	5,783,149	9.4%
Michigan	82,557,687	6,200,000	7.5%
Minnesota	56,435,519	5,634,625	10.0%
Mississippi	9,507,924	946,925	10.0%
Missouri	37,086,332	3,703,052	10.0%
Montana	8,149,452	743,191	9.1%
Nebraska	14,572,410	1,457,421	10.0%
Nevada	2,688,931	321,000	11.9%
New Hampshire	10,696,265	1,421,636	13.3%
New Jersey	53,716,381	5,300,000	9.9%
New Mexico	6,240,885	619,635	9.9%
New York	179,653,155	20,265,284	11.3%
North Carolina	23,934,357	2,291,480	9.6%
North Dakota	9,490,131	949,013	10.0%
Ohio	77,222,336	5,630,000	7.3%
Oklahoma	9,507,560	866,359	9.1%
Oregon	16,186,857	1,592,977	9.8%
Pennsylvania	97,613,453	7,988,700	8.2%
Rhode Island	9,455,635	1,015,000	10.7%
South Carolina	8,842,800	906,498	10.3%
South Dakota	7,738,757	590,459	7.6%
Tennessee	17,858,024	321,257	1.8%
Texas	29,123,333	2,912,333	10.0%
Utah	9,497,067	936,489	9.9%
Vermont	8,381,600	790,770	9.4%
Virginia	26,527,099	2,525,098	9.5%
Washington	26,113,499	2,530,311	9.7%
West Virginia	11,651,060	1,165,106	10.0%
Wisconsin	54,533,382	5,145,000	9.4%
Wyoming	3,850,267	387,272	10.1%

Table E-2 presents information on the series of surveys that were used to prepare this Appendix. The reader should note that the in-home interview dates lag behind the analysis year for the years 1979 through 1985. In those years, the energy supplier survey included data from the year following the in-home interview. In all cases, the analysis year coincides with the end of the energy consumption history.

Table E-2. Data used for the study of low-income home energy trends

	Analysis year ¹							
	1979	1981	1983	1985	1987	1990	1993	FY 1994
Survey ²	NIECS	RECS	RECS	RECS	RECS	RECS	RECS	RECS
Interview date ³	9/78	9/80	9/82	9/84	9/87	9/90	10/93	
Billing date ⁴	4/78-3/79	4/80-3/81	4/82-3/83	4/84-3/85	1/87-12/87	1/90-12/90	1/93-12/93	10/93-9/94
Income data	1979 ⁵	1981 ⁵	1983 ⁵	1985 ⁵	1987 ⁵	1990 ⁵	1993 ⁵	1994 ⁵
Sample size	4,081	8,051	4,724	5,682	8,229	5,095	7,111	7,111

¹Represents the year that includes the last month for which billing data were collected from fuel suppliers.

²Surveys include the National Intermittent Energy Consumption Survey (NIECS) and the RECS.

³Month in which household interviews began.

⁴Data projected from the 1985 RECS using microsimulation methods to model changes in weather and prices.

⁵Time period in which residential energy bills were collected from fuel suppliers.

⁶Mean income computed using calendar year data from the March Current Population Survey (CPS).

Trends in consumption, expenditures, and burden

Since 1979, there have been important changes in the fuels used by households, the amount of energy consumed for specific residential end uses (i.e., home heating, water heating, home cooling, and other appliances), total residential energy expenditures, and the burden that residential energy expenditures represent for low income households. In this section, data that illustrate these changes are presented.

Figures E-1 and E-2, on the next page, furnish information on the fuel choices by low income households. Figure E-1 shows that low income households have increased their use of electricity as a main heating fuel, from 10.4 percent in 1979 to 27.2 percent in 1993, while they have reduced their use of fuel oil as a main heating fuel, from 20.0 percent in 1979 to 10.9 percent in 1993.³ In addition, the use of wood or coal as a main heating fuel (included under "other") peaked in 1985 but has declined substantially since.

Figure E-2 shows that low income households increased their use of electric central air-conditioning systems from 7.3 percent in 1979 to 26.1 percent in 1993.⁴ The proportion of low income households with no air conditioning fell from 62.8 percent in 1979 to 39.6 percent in 1993. Other things being equal, increased use of air-conditioning equipment among low income households can be expected to increase home cooling expenditures.

³For all households, the incidence of electric main heat grew from 19.4 percent in 1979 to 25.8 percent in 1993, and the incidence of fuel oil main heat fell from 14.5 percent to 10.5 percent.

⁴For all households, the incidence of electric central air conditioning grew from 26.9 percent in 1979 to 43.1 percent in 1993.

Figure E-1. Main heating fuel for households with incomes at or below 150 percent of the poverty income guidelines, 1979 to 1993

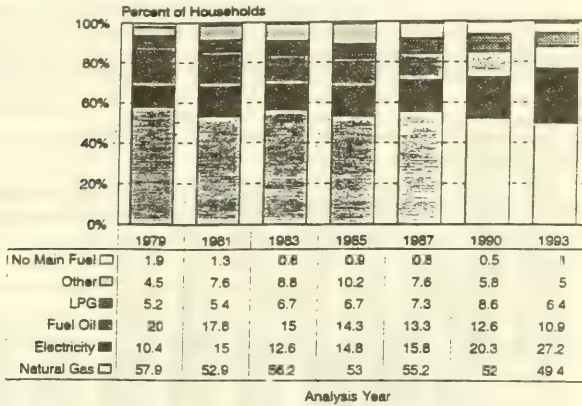
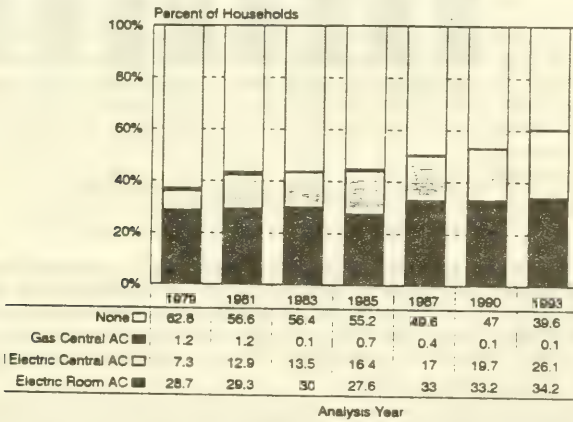


Figure E-2. Main air conditioning type for households with incomes at or below 150 percent of the poverty income guidelines, 1979 to 1993



Figures E-3 and E-4 furnish information on the trends in mean residential energy consumption and expenditures for low income households from 1979 to FY 1994.

Figure E-3 shows that low income households substantially reduced their residential energy consumption between 1979 and 1983. Examination of the components of residential energy consumption indicates that the reduction was the result of reductions in home heating consumption. From 1983 to 1990, mean residential energy consumption fluctuated from year to year, corresponding to expected changes in heating and cooling consumption due to changes in heating and cooling degree days.⁵ For 1993 and FY 1994, there appears to have been a significant increase in the use of energy for purposes other than home heating and home cooling.

Figure E-3. Mean residential energy consumption per household in mmBTUs by end use for households with incomes at or below 150 percent of the poverty income guidelines, 1979 to FY 1994

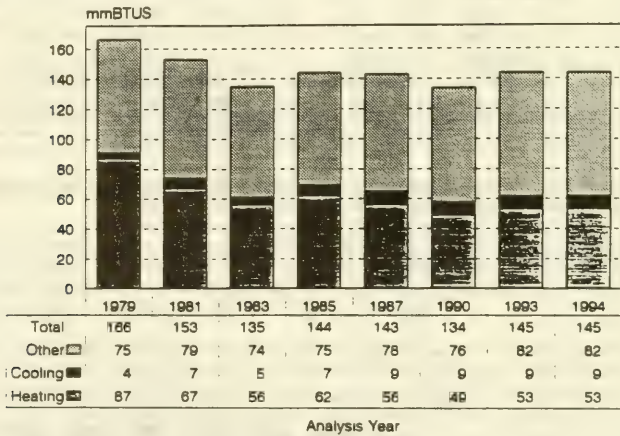
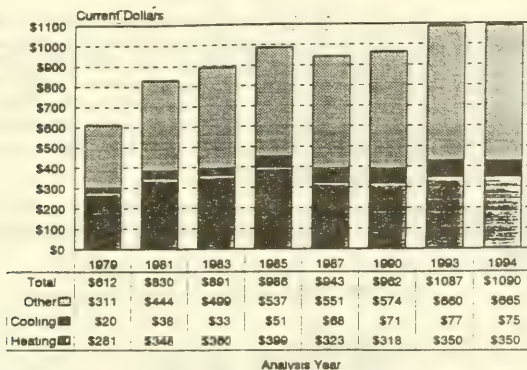


Figure E-4, on the next page, shows that residential energy expenditures for low income households increased rapidly from 1979 to 1985, due to fuel price increases. Examination of the components of energy expenditures indicates that the greatest increases were in home cooling and other residential expenditures, while increases in home heating expenditures were more moderate. Since 1987, mean residential energy expenditures

⁵The numbers presented in this table are not directly comparable to the statistics that appear in Appendix B. In this figure, electricity BTUs have been adjusted to be comparable to BTUs for other fuels. This adjustment procedure is used to account for BTUs lost in the generation and transmission of electricity to the housing unit and thereby furnish a better picture of changes in energy efficiency over time.

have increased at a moderate rate, from \$943 in 1987 to \$1,090 in FY 1994. Mean home heating expenditures fell from \$399 in 1985 to \$318 in 1990, and then rose moderately to \$350 in 1993 and FY 1994. Mean home cooling expenditures rose continuously from \$51 in 1985 to \$77 in 1993. They fell to \$75 in FY 1994.

Figure E-4. Mean residential energy expenditures by end use for households with incomes at or below 150 percent of the poverty income guidelines, 1979 to FY 1994



The next series of charts, E-5a through E-5c, furnishes information on energy burden for low income households.⁶ Three different energy burden summary statistics are presented in the three charts — mean group energy burden, mean individual energy burden, and median individual energy burden.⁷ Each of the statistics offers somewhat different information and gives somewhat different results. All three are valid from a statistical perspective. The statistics are defined as follows:

- **Mean Group Burden:** Computed as the ratio between mean energy expenditures and mean income for low income households. Energy expenditures are computed from RECS and income is computed from the CPS.
- **Mean Individual Burden:** Computed by first computing the energy burden for each individual low income household from the RECS and then taking the mean of the energy burden statistic for all low income households.

⁶These charts present gross burden statistics; they do not account for the reduction in burden attributable to the receipt of LIHEAP benefits. Figure E-21 compares gross burden and net burden for LIHEAP recipient households.

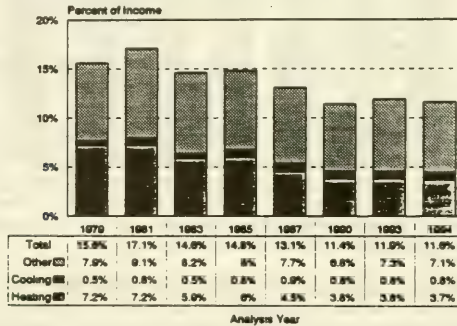
⁷The mean is the sum of all values divided by the number of values, or what is commonly called the average. The median is the value at the midpoint in the distribution of values.

- **Median Individual Burden:** Computed by computing the energy burden for each individual low income household from RECS and finding the median, or middle point, of the distribution of household-level energy burdens.

Mean group burden is the burden statistic that has been used in the series of LIHEAP Annual Reports to Congress. Recent technical research has furnished additional insights on the range of alternative burden summary statistics. (See Appendix B for additional information on the interpretation of alternative burden statistics.)

Figure E-5a shows the time series for mean group energy burdens by end use for low income households. Mean group home energy burden grew from 7.7 percent of income in 1979 to 8.0 percent in 1981, and then fell considerably after 1981. In FY 1994, mean group home energy burden was 4.5 percent. Mean group home energy burdens declined because mean home energy expenditures for low income households fell, while mean incomes for low income households rose. Mean group residential energy burdens were stable from 1979 to 1985, and then fell from 1985 until 1990. Mean group residential energy burdens have been stable since 1990.

Figure E-5a. Mean group residential energy burden by end use for households with incomes at or below 150 percent of the poverty income guidelines, 1979 to FY 1994



Tables E-5b and E-5c show how the mean individual and median individual energy burden statistics compare to the group energy burden statistics. Table E-5b shows the trends in residential energy burden for low income households, and Table E-5c shows the trends in home energy burden for low income households. In FY 1994, the mean individual residential energy burden was 16.2 percent, significantly higher than the median individual burden of 10.7 percent and the group burden of 11.6 percent. In FY 1994, the mean individual home energy burden was 6.5 percent, the median individual burden was 4.1 percent, and the group burden was 4.5 percent. For all three summary statistics, the highest home energy burden occurred in 1981, while the lowest occurred in FY 1994. For all three statistics, the FY 1994 value was about 40 percent lower than the 1981 peak.

Figure E-5b. Comparison of mean group, mean individual, and median individual residential energy burden for households with incomes at or below 150 percent of the poverty income guidelines, 1979 to FY 1994

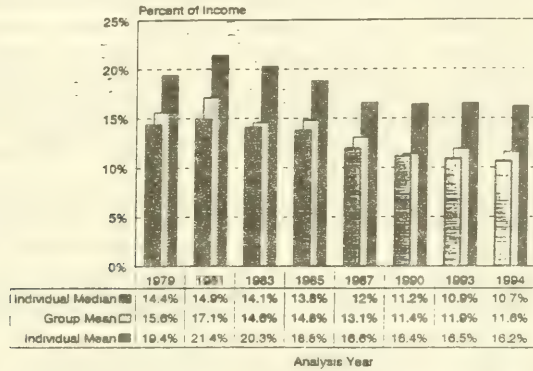
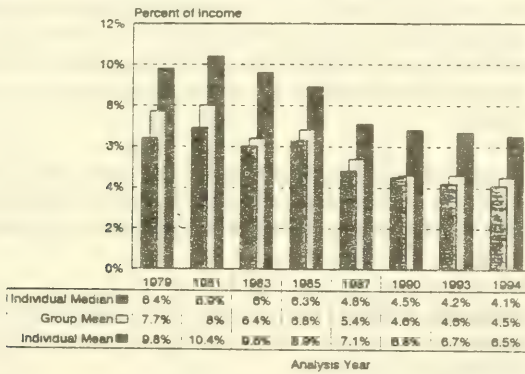


Figure E-5c. Comparison of mean group, mean individual, and median individual home energy burden for households with incomes at or below 150 percent of the poverty income guidelines, 1979 to FY 1994



LIHEAP - LEVERAGING

Mr. Porter: Please describe the criteria for determining increased state allotments for the leveraging incentive program. What states received increased allocations and in what amounts relating to the leveraging incentive program.

Ms. Bane: The leveraging incentive program is designed to reward grantees that add nonfederal resources to help low income people meet their heating and cooling needs. Grantees that wish to receive leveraging incentive funds must submit a separate application that reports the leveraging activities carried out during one fiscal year in order to qualify for leveraging incentive funds the following year (e.g., leveraging incentive awards for FY 1996 are based on countable leveraging activities carried out during FY 1995).

An interim final rule issued on January 16, 1992 (57 Fed. Reg. 1960) as modified by a final rule issued on May 1, 1995 (60 Fed. Reg. 21322) lays out criteria that leveraging resources must meet in order to count under the leveraging incentive program. Each countable leveraging resource will earn the grantee a share of the funds set aside for leveraging incentive grants for that year.

A formula for distributing leveraging incentive funds was established by the interim final regulation in January 1992 and modified in the final rule issued in May 1995. The formula includes two separate calculations:

- Percent of Regular Grant Leveraged: Half of the leveraging funds are distributed based on the amount of leveraging activities each grantee carried out as a proportion of the amount of its regular LIHEAP grant, taking into account the amount of leveraging activities carried out by all grantees as a proportion of their regular grants.
- Percent of All Leveraged Funds: The other half of the leveraging funds are distributed based on the amount of leveraging activities carried out by each grantee as a proportion of the total amount leveraged by all grantees.
- Limits on Awards: To keep any one grantee from receiving a disproportionate share of the leveraging incentive fund, there are two limiting factors:
 - + No single grantee can receive more than 12% of the total amount available for incentive grants.
 - + No grantee can receive more than the lesser of the amount of its regular grant or twice the amount leveraged. (The first half of the formula can give very small grantees hugely disproportionate amounts without this limit.)

Example: Under the first half of the formula, a grantee with an allocation of \$20 million that leveraged \$2 million would get the same amount as a grantee with an allocation of \$100 million that leveraged \$10 million because both leveraged 10 percent of their allocations. This part of the formula was designed to give smaller grantees credit for level of effort. It would be much easier for the \$100 million grantee in the above example to raise \$2 million in leveraged resources than for the \$20 million grantee to do so.

Under the second half of the formula, if the total amount of leveraged resources for all grantees was \$500 million, the \$20 million grantee in the example above that leveraged \$2 million would receive 0.4 percent of this half of leveraging funds, while the \$100 million grantee that leveraged \$10 million would receive 5 times that amount, or 2 percent. This part of the formula was designed to reward grantees that leverage large amounts of resources.

We have found that the two halves of the formula provide a good balance and fair incentives and awards for both large and small grantees.

Listed in the attached table are the 69 LIHEAP grantees (44 States and 25 Indian tribes or tribal organizations) that received a share of the \$30 million in leveraging incentive grant awards for FY 1995 (based on FY 1994 leveraging activities). The FY 1996 leveraging incentive award applications are currently being reviewed.

Grantee	FY 1994	FY 1994 Leveraging \$	Total Share of \$30 M Allot \$ for FY 1995
Alabama	\$5,591,145	\$ 12,054,122	\$557,284
Alaska	7,244,346	5,178,324	1,404,810
Arizona	4,030,049	5,168,464	782,770
Arkansas	250,806	9,253,168	30,387
California	77,168,290	64,620,824	3,235,983
Colorado	8,275,294	22,682,886	549,590
Connecticut	14,551,916	34,985,844	773,422
Delaware	258,006	4,214,066	59,786
Dist. of Col.	1,960,810	4,595,473	421,327
Florida	150,658	19,173,438	11,046
Idaho	827,433	8,716,921	104,957
Illinois	5,814,167	93,921,206	219,797
Indiana	1,131,544	39,407,935	57,035
Kentucky	1,033,558	24,638,883	65,547
Louisiana	317,335	12,390,034	31,019
Maine	7,358,392	26,365,346	449,930
Maryland	20,813,164	29,288,356	1,205,217
Massachusetts	43,261,125	73,053,759	1,747,998
Michigan	17,252,473	126,360,604	611,859
Minnesota	6,345,319	93,420,464	240,186
Mississippi	474,780	10,379,303	52,760
Missouri	1,469,385	32,714,753	80,591
Montana	2,050,536	8,806,656	258,052
Nevada	290,221	2,754,413	98,477
New Hampshire	2,405,694	14,351,322	212,450
New Jersey	86,689,186	61,739,044	3,688,807
New York	145,174,223	240,645,272	4,681,782
North Carolina	2,545,684	26,242,725	156,042
North Dakota	143,683	16,546,795	11,552
Ohio	31,511,897	96,381,778	1,183,935
Oklahoma	1,070,088	10,276,943	119,793
Oregon	3,505,823	17,570,961	271,305
Pennsylvania	72,856,412	116,857,601	2,623,969
Rhode Island	1,910,816	11,470,716	197,354
South Carolina	359,897	9,630,991	42,299
South Dakota	375,732	9,493,377	44,644
Tennessee	316,410	19,548,225	22,928
Utah	386,199	10,334,889	43,053
Vermont	449,599	13,196,404	42,050
Virginia	1,186,751	28,277,434	69,960
Washington	13,299,192	27,788,023	791,085
West Virginia	3,301,100	16,503,089	456,532
Wisconsin	27,549,381	65,146,937	810,168
Wyoming	97,000	4,220,301	22,448

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

- FY 1995 Leveraging Incentive Grant Awards Page 2 of 2

Grantee	FY 1994 Leveraging \$	FY 1994 Allot \$	Total Share of \$30 M for FY 1995
Alaska			
Tanana Chiefs Conf.	\$18,517	\$ 618,924	\$26,128
Tlingit & Haida CC	13,500	424,642	27,588
Arizona			
Quechan Tribe	17,308	15,826	15,826
California			
Quartz Valley Rn.	249	3,057	3,057
Rincon Ind. Resv.	8,192	12,151	12,151
Round Valley(Covelo)	24,710	22,538	22,538
Idaho			
Shoshone-Bannock Tr.	23,153	99,004	99,004
Massachusetts			
Mashpee Wampanoag	6,402	17,453	17,453
Michigan			
Inter-Tribal Council	36,336	60,610	60,610
Sault Ste. Marie Tr.	30,000	150,678	150,678
Montana			
Assin & Sioux			
(Ft Peck)	19,700	307,571	55,366
Blackfeet Tribe	33,264	497,270	58,187
Con Salish Kootenai	17,590	285,093	53,293
New Jersey			
Powhatan			
Renape Ntn	1,449	154,742	8,054
North Carolina			
Lumbee	5,260	496,155	9,221
Oklahoma			
Choctaw Nat of OK	100,000	146,901	146,901
Kiowa Tribe of OK	10,875	20,377	20,377
Muscogee Creek Ntn	50,000	101,785	101,785
South Dakota			
Lower Brule Sioux	50,000	39,495	39,495
Siss-Wahpeton			
Sioux Tr	31,668	151,111	151,111
Washington			
Colville Conf Tribe	43,920	244,927	154,682
Lummi Tribe	4,400	72,264	52,221
Port Gamble S'Kl Tr	1,157	11,914	11,914
Puyallup Tribe	17,836	80,592	80,592
Yakama Nation	<u>24,000</u>	<u>259,617</u>	<u>79,782</u>
Total	623,645,002	\$1,584,662,766	\$30,000,000

Mr. Porter: P.L. 103-252, which reauthorized LIHEAP through FY 1999, established a Residential Energy Assistance Challenge (REACH) grant program to help reduce recipients' home energy costs. Has the REACH program been implemented nationwide? Specifically, how many States have implemented it? How does it work? What services are provided? Aren't there other programs that provide counseling services to low-income persons about energy needs and costs, and what to do to lower such costs? Does the REACH program duplicate such services provided by other agencies?

Ms. Bane: Under the terms of P.L. 103-252, REACH is to be funded for the first time in FY 1996. A program announcement specifying the detailed requirements for applications will be published shortly so that the first grant awards under the program can be made by September. At this time, we are uncertain how many grantees will be funded or what specific services will be provided.

We are not aware of any other programs that offer such services targeted to LIHEAP recipients on a national basis. There are similar programs being designed on a State or local basis in some areas which may use either LIHEAP or other Federal funds.

Mr. Porter: According to the Department, LIHEAP benefits vary widely by State. For example, in FY 1995, LIHEAP grantees reported average benefits ranging from \$58 to \$412 for heating assistance, from \$70 to \$500 for winter crisis aid, and from \$100 to \$221 for cooling assistance. These figures seem to indicate that some States are doing a better job than others of targeting assistance to households with greatest need. Don't these figures suggest that LIHEAP funding is not effectively targeted nationwide?

Ms. Bane: There are many reasons that benefit levels vary from State to State. Variations in the relative size of State allotments, in the type and price of energy used, and in climatic and economic conditions probably account for most of the difference. These factors affect the number of households in need, the level of benefit that provides meaningful assistance, and the amounts provided to individual households.

In addition, in the past the LIHEAP statute limited the ability of States to target assistance. For example, before 1994 the statute included a prohibition against excluding households whose incomes were below 110% of the poverty level. In 1994, the law was revised to allow States to give priority in eligibility as well as benefit levels to households with high energy burdens or needs, even if the practical effect was to exclude other households with income under 110% of the poverty level. In response, States are developing ways to improve their targeting.

REFUGEES

Mr. Porter: What is the amount of funding carried forward from FY 94 to FY 96 for Refugee programs?

Ms. Bane: For FY 1994, our current estimate is that \$10,030,866 in Federal unobligated funds from the Transitional and Medical Assistance (TAMS) line item would be available for carry-over.

Mr. Porter: The FY 96 appropriations bill limits funding for domestic preventive health activities to \$2.7 million to be administered in accord with the Secretary's decisions. How will this funding be used, and how will it be administered?

Ms. Bane: We do not have an answer for the Committee at this time. We will provide that information to Committee Staff at a later date.

Mr. Porter: Specifically, will it be administered in accord with the ORR protocol on domestic refugee health screening?

Ms. Bane: This screening will be conducted in accordance with the Health Screening Protocol issued by ORR last year.

Mr. Porter: The House recently adopted legislation requiring that Targeted Assistance be allocated to states on the basis of numbers of refugees served without regard to the cost of serving those individuals. What impact would this legislation have on the Targeted Assistance program if enacted?

Ms. Bane: The amendment which requires that targeted assistance funds, with the exception of targeted assistance discretionary funds, be allocated to States based on the number of refugees and entrants residing in each qualified county who arrived in the U.S. within the past 5 years would have the following impact:

1. Two States would lose funds: Florida would lose approximately \$15.7 million, while New Mexico, a new targeted assistance State in FY 1996, would lose approximately \$345,000.
2. Several States would gain a significant amount of funds: California (\$5.8 million), New York (\$3.7 million), Texas (\$1.1 million), Illinois (almost \$848,000), and Washington (\$787,000).
3. The remaining 13 targeted assistance States would also experience some increase in funds.

CHILD ABUSE

Mr. Porter: Do all States receive funds under the Child Abuse Prevention and Treatment Act? For what reasons would a State not receive funds?

Ms. Bane: All States which applied last year received grants under the Basic State, the Children's Justice Act, and the Community-Based Family Resource Program (CBFRP). Neither Indiana nor Pennsylvania have applied for or received a Child Abuse and Neglect Basic State Grant. Since Children's Justice Act funding is contingent upon Basic State Grant funding, these States also do not receive funding under that Act. In addition, Alaska, Florida, Wyoming and Puerto Rico have not applied for or received Children's Justice Act funding. Puerto Rico also did not apply for a CBFRP grant.

CHILD WELFARE

Mr. Porter: How do States use their child welfare services funds (under title IV-B, subpart 1 of the Social Security Act)?

Ms. Bane: Publicly funded child welfare services are directed toward the goal of keeping children safe and families together. They include preventive intervention so that, if possible, children will not have to be removed from their homes. If removal is necessary, placements and permanent homes can be arranged through foster care or adoption. In addition, reunification services are available to encourage the return home, when appropriate, of children who have been removed from their families. Many of the States also use title IV-B funds to pay child welfare staff.

Mr. Porter: How does this differ from their use of State grant funds under the Child Abuse Prevention and Treatment Act?

Ms. Bane: The primary focus of the Child Abuse Prevention and Treatment Act (CAPTA) funds and title IV-B funds is very different. One of the primary goals of CAPTA is to assist States with developing comprehensive, child-centered, family-focused, and community-based child protection systems. For example, states use CAPTA funds to support multi-disciplinary training, to pilot risk assessment projects, and to improve reporting by professionals, among other purposes. Child welfare services under title IV-B, on the other hand, are directed toward the goal of permanency for children. Services are provided either to keep families together or, for children who have been removed from their families, to encourage their return home, when appropriate, or their placement in an alternative permanent home.

Mr. Porter: What data do you collect on State use of funds under either program?

Ms. Bane: State child welfare agencies and eligible Indian Tribal Organizations are required to submit estimated title IV-B, subpart 1, expenditures for the upcoming year as part of their annual budget requests. Expenditures are listed according to the specific services and activities for which the funds are projected, such as protective services, prevention services, family preservation and support services, adoption, and foster care services. Additionally, States estimate the number of clients to be served, the populations to be served and the geographic areas to be served within each of these specific services or activities.

The CAPTA Basic State grant requires a semi-annual fiscal report on the amount of funds used. States also provide narrative information on their planned use of funds in their applications and report on their progress in their semi-annual reports.

Mr. Porter: Administration, child placement, and training costs related to foster care and adoption currently are matched under title IV-E on an open-ended entitlement basis. In recent years these administrative costs have grown at a faster rate than spending for foster care or adoption assistance payments. Please describe the types of activities that comprise administrative and child placement costs. What proportion of these costs are used for traditional administrative and overhead expenses, as compared to case planning and management and other activities on behalf of foster children?

Ms. Bane: Administrative and child placement costs include referrals to services, preparation for and participation in judicial determinations, placements of children, development of case plans, case reviews, case management and supervision, the recruitment and licensing of foster homes and institutions, and related agency overhead. In FY 1994, 28 percent of State foster care expenditures claimed were for administrative and overhead expenses. The remaining 72 percent were spent on case planning/management and related pre-placement activities.

Mr. Porter: Why have administrative and child placement costs grown so rapidly?

Ms. Bane: Administrative and child placement funds support critical components of the child welfare system such as preplacement activities, recruitment of foster parents and case management. States have been striving to improve their capacity to deliver appropriate services to children and families and have, therefore, been increasing their expenditures for the development of statewide automated child welfare information systems (SACWIS) as well as providing increased training for their own staff and for foster parents.

Mr. Porter: What would be the impact on States of including these costs in a block grant, or placing a cap on their growth rate?

Ms. Bane: The Federal government is working aggressively with its State partners to reform the child welfare system and to improve services in all States through a revised monitoring strategy that focuses on the outcomes of safety, permanency and well-being for children; support for comprehensive planning for enhanced services; and a heightened focus on timely decision-making and permanency planning. Enhanced services include improved training and child placement services, both of which are currently covered by administrative costs. A cap on "administrative" funds would severely restrict activities to promote child safety, quick decision making and permanency. Should foster care caseload continue to grow as projected, a cap could hamper States' ability to respond with commensurate protective services.

A block grant would end the focus on prevention and eliminate the basic protection for children in care, such as requiring that reasonable efforts be made to preserve the family, periodic reviews of children placed in foster care, permanency planning determinations and case plan requirements. A harnessing of Federal, State and community efforts is needed to spark the evolution of an effective child welfare system that prevents abuse and neglect and keeps children safe.

In addition, a block grant cannot adjust to changes in population, the impact of a recession, or unpredictable crises like the AIDS tragedy or the crack epidemic of recent years. Therefore, there would be no guarantee of protection for these abused and neglected children.

FAMILY PRESERVATION AND SUPPORT

Mr. Porter: In 1993, Congress enacted a new Family Preservation and Support program, which is a five-year capped entitlement grant to States intended to result in the development of services that could strengthen vulnerable families and avoid the need to place children in foster care. Please describe implementation of the Family Preservation and Support program.

Ms. Bane: There are several aspects to the Federal implementation of the Family Preservation and Family Support Program. Before providing guidance to the States, the Department conducted an extensive series of focus groups designed to solicit advice from the field on principles critical to the success of these preventive service programs, and these principles were incorporated into the annual guidance and regulations that were developed.

In 1994 and 1995, the States conducted intensive year-long planning processes in partnership with a wide range of stakeholders with the goal of building a comprehensive continuum of care for vulnerable children and families. This process led to the development of 5-year comprehensive child and family service plans which were submitted to the Department in June 1995. Annual progress and services reports will be due from the States beginning in June 1996.

Additionally, three evaluation studies are being conducted to assess the implementation of the Family Preservation and Family Support program as well as the effectiveness of the various family preservation and support interventions that are being employed. Training and technical assistance is also being provided through seven national resource centers specializing in key areas of child welfare practice such as legal issues, family-based services, adoption, respite care, and permanency.

Mr. Porter: How are States using their funds, and what is the status of your evaluation process?

Ms. Bane: State goals reflect family-centered service principles and are not limited to those typically associated with the child welfare system. Sixteen States, for example, have established goals pertaining to interagency collaboration.

While most States already provide a comprehensive family preservation program, many States are concentrating their new efforts on building statewide networks of family support services.

The States have been able to use the resources flexibly and creatively to bring together the services families need. Programs funded by the States are typically community-based and range from home-visiting and family centers offering mentoring, health education, parenting classes and support groups to crisis management.

Although the two program types supported by the legislation share the ultimate goal of children's and families' well-being, they differ considerably in the types of services provided, the populations served, program philosophy and mission. Therefore, the Department decided that different evaluation approaches were needed and that the evaluation efforts should be separated from the task of examining the implementation of the legislation. Three linked research efforts were initiated, sponsored by three collaborating offices within the Department: the Office of the Assistant Secretary for Planning and Evaluation, ACF's Office of Planning, Research and Evaluation, and the Administration on Children, Youth and Families.

The first effort, The Evaluation of Family Preservation and Reunification Services, is designed to determine the extent to which family preservation and reunification programs can reduce the number of children in foster care and the extent to which these programs are effective in improving family functioning. This study involves experimental designs, with families being randomly assigned to experimental or control groups in six sites. Data collection for this study was recently approved by the Office of Management and Budget, and procedures for conducting the study are being finalized.

The second effort, The Evaluation of Family Support Programs, is intended to describe the wide variety of family support programs as they currently exist, and to assess their effectiveness in enhancing the well-being of children and families. An extensive national review of existing programs has been completed, and a topology of family support programs has been developed. The next phase of the study, which involves data collection to evaluate eight programs representing key elements of family support, is expected to begin in the late fall.

The third effort, The Family Preservation and Family Support Implementation Study, is designed to examine the processes that States employed in implementing the legislation, the barriers encountered, the types of programs developed, and the changes in service delivery systems. The review of State applications and plans has been completed, and clearance was recently received from the Office of Management and Budget to conduct intensive case studies of how the plans are being implemented in ten States.

Mr. Porter: What information do you have about State use of court improvement grant funds? Are all States participating in this program?

Ms. Bane: The direct funding to the State courts has enabled the courts and child welfare agencies to engage in joint planning for system reform. Prior to the funding, open lines of communication between the two systems did not exist in many States. In addition, proposals for reform are currently under consideration in many courts, which just this year completed comprehensive assessments of their systems.

Forty-eight States, including the District of Columbia, are participating in the Court Improvement Program. Pennsylvania, Idaho, and Wyoming are not participating due to the reluctance of their Supreme Courts to engage Federal funds.

SOCIAL SERVICES BLOCK GRANT

Mr. Porter: In the Family Support Act of 1988, Congress required States to submit annual reports on their use of SSBG funds, containing specific information. HHS issued final regulations, implementing the 1988 legislation, on Nov. 13, 1993. Have all States submitted reports as required? What fiscal years are covered by the reports submitted thus far? Are these reports in a reasonably uniform format that would allow national comparisons?

Ms. Bane: Yes, all States have submitted the required reports.

States have been submitting the annual reports since FY 1989 and we are currently receiving reports for FY 1995, the most recently completed fiscal year.

While we are getting data which provides information on the numbers of recipients receiving services and funding (Federal, State and local), the nature of the Social Services Block Grant permits States to design social services programs best suited to the needs of individuals within the State. For this reason, social services programs differ from State to State and make national comparisons difficult.

Mr. Porter: What plans do you have for compiling, analyzing and disseminating these State reports, so that Congress and the public can have comparable, national information on the use of SSBG funds?

Ms. Bane: As I indicated previously, we are getting specific data on numbers of recipients and funding provided for specific services under the SSBG. States were given a full fiscal year after publication of the final regulations to put systems in place to capture the required information. When we have all of the annual reports in for FY 1995 (due by the end of October 1996), the information contained in these reports could be made available to the Congress and the public.

Mr. Porter: In the Reconciliation Act of 1993, Congress authorized an additional \$1 billion for the SSBG, to be used in designated empowerment zones and enterprise communities. These funds were included in the FY 1994 appropriations act. Of the \$1 billion provided in FY 1994, what amount has been spent?

Ms. Bane: All of the \$1 billion provided in FY 1994 has been obligated and released to the States.

Mr. Porter: How long are these funds available for obligation and expenditure?

Ms. Bane: The EZ/EC SSBG funds must be obligated within two years of the date of the grant award and spent within ten years of the date of the grant award. Grants were awarded in two rounds. Empowerment Zones received half of their funding on October 1, 1995. Empowerment Zones received the second half of their funding on December 21, 1995 and Enterprise Communities received their total funding on this date.

Mr. Porter: Do you have information about how the designated Zones and Communities are using or plan to use their special SSBG funds?

Ms. Bane: Yes. The strategic plans that were submitted to HUD and USDA as part of the applications for funding include detailed information on how Zones and Communities plan to spend the grant funds. In addition, this information can be found in the Benchmark Agreements negotiated by HUD and USDA.

Mr. Porter: During the FY 96 hearing, Ms. Bane indicated that HHS does not conduct any program assessments of the Social Services Block Grant and therefore does not know how the funding is spent or what results are obtained. Is this still the case, and if not, on what basis does the Administration continue to request funding for the program?

Ms. Bane: While it is correct that HHS has not conducted program assessments of the Social Services Block Grant, the Department does have information on how funds are used under the program and the various social services programs that States have put in place to serve the needs of their population. This information is obtained through pre-expenditure reports submitted by States prior to each fiscal year, the annual report of expenditures, State audits, HHS Inspector General reports, GAO audits and reviews.

Mr. Porter: Are Cubans entering under the lottery established under the Cuban Migration Program required to have affidavits of support as a condition of their admission? If so, are the sponsors' incomes deemed to be available for the purpose of determining eligibility for SSI, AFDC, and Food Stamps in the same manner that they are for sponsored immigrants?

Ms. Bane: Under the Cuban Migration Program, Affidavits of Support depend on the marketable employment skills of the individual and the likelihood of becoming a public charge. For those who will be required to obtain an Affidavit of Support, there will be no deeming of income because section 415(f)(5) of the Social Security Act exempts Cuban/Haitian entrants, as defined in section 501(e)(2) of the Refugee Education Assistance Act of 1980, from the deeming provisions of the Act. Cubans entering the U.S. under the Cuban Migration Program meet the 1980 definition of Cuban/Haitian entrant. We understand that deeming would also not apply under the SSI and Food Stamp programs.

TITLE IV-A EMERGENCY ASSISTANCE FUNDS

Mr. Riggs: How did your agency come to the conclusion that it no longer needed to fulfill contractual obligations under AFDC-EA Title IV-A that it had to States providing services within their juvenile justice system?

Ms. Bane: We have always met the Department's partnership and matching obligations for all expenditures authorized for the Emergency Assistance (EA) program by Section 406(e) of the Social Security Act (the Act). During a study of EA, the Department's Inspector General questioned the allowability of certain types of EA costs. We carefully re-examined these policies in light of Congress' statutory intent for the EA program. We concluded that costs for services provided to children in the juvenile justice system due to alleged, charged, or adjudicated delinquent behavior bear no valid relationship to the statutory purpose of EA -- to address the emergency needs of families.

Instead of disallowing Federal matching of all prior claims, we notified States that Federal funding would no longer be available for the costs of juvenile justice services. And, to minimize the impact on our partners, we allowed States that had approved juvenile justice plans to claim these inappropriate costs for more than three additional months.

Mr. Riggs: How do you reconcile the fact the Federal law allows each State to define what they consider "emergency situations" as long as that definition is consistent with the intent of the law with the consequent denial of funding to those States even though they feel that their definitions are consistent with the intent of the original law?

Ms. Bane: States do have wide flexibility in developing their EA programs. A State is permitted to define the types of emergencies, services and eligibility criteria it will cover so long as the program's scope is defined equitably and bears a valid relationship to the purpose of the program. But, under the system of cooperative federalism envisioned in the Social Security Act, Congress has delegated to the Secretary the authority to reconcile a statute's policy objectives, issue implementing regulations and necessary policy interpretations.

With respect to Emergency Assistance, the legislative history is particularly clear that the context of the program is the family. The juvenile justice system operates in the context of society rather than in the context of family. This agency interpretation was recently upheld in a court decision, *Chief Probation Officers of California vs. Shalala*.

Mr. Riggs: Even if you have come to the conclusion that use of these funds in the juvenile justice system are not appropriate, why did you implement this termination mid-fiscal year and not for FY 1997 forward?

Ms. Bane: When we determined that Federal financial participation is not available under the Emergency Assistance program for costs associated with providing benefits or services to children in the juvenile justice system, we recognized the difficult choice that we and the States faced. Since we concluded that we should not have allowed these claims in the first place, we acted to stop the practice as soon as possible. But, we also wanted to give States a reasonable period of time to modify their procedures and implement this policy. Since State fiscal years vary, we allowed States to continue to claim Federal matching for costs through December 31, 1995 as an appropriate balance between State and Federal interests.

Mr. Riggs: Even though the agency had approved these contracts and the described use of funds in each contract and had budgeted this money for FY 1996?

Ms. Bane: In retrospect and following our re-examination of Congressional intent, it is clear that the State plans adding services and benefits to children in the juvenile justice system should not have been approved. But, once we recognized our mistake, we initiated reasonable and expeditious action to appropriately correct the situation.

Mr. Riggs: Even though these States had operated in good faith that the Federal government would fulfill that obligation?

Ms. Bane: When we determined that the State plans including services and benefits to children in the juvenile justice system did not meet Congressional intent, we had no choice under the Social Security Act but to end the practice.

Mr. Riggs: Was the elimination of this funding simply a means by which to make up for lack of funding elsewhere in your agency rather than have to come to Congress for a supplemental appropriation as is sometimes the case for our agency?

Ms. Bane: Funding for Title IV-A Emergency Assistance is available to cover program needs due to the indefinite authority provided by Congress and does not need a supplemental appropriation. Our policy change about children in the juvenile justice system was solely the result of the re-examination of statutory intent, and not due to funding needs.

JOB OPPORTUNITIES AND BASIC SKILLS TRAINING PROGRAM (JOBS)

Mr. Riggs: In 1993, Lake County, California established a public/private partnership with a nationally known firm (Maximus) to finance and administer their local GAIN (JOBS) program. They made that decision in order to avoid spending local tax dollars that are desperately needed elsewhere in the community.

As a result, costs to local taxpayers have been dramatically reduced as a result of this prudent contract, the statistics of the program prove beyond a doubt that the service levels to the public have been improved.

As part of the contract entered into, the firm proposed making an unrestricted annual cash donation to the County equal to the amount the County must provide as the local matching funds for this program. This was not a requirement of the request for proposal as has been indicated by your Department.

Twenty months into the contract, the Federal Government, specifically your agency, decided that the nature of the donation provided by the firm rendered Lake County ineligible for the Federal match totaling \$97,000. Although we attempted to work with your agency to address this issue in an equitable manner, it is my understanding that the decision to deny these funds remains firm.

As a result of an October 27, 1995 meeting with Mary Jo Bane/ACF, I was told that HHS would take steps to ensure that future federal policies would help facilitate, not discourage, public/private partnerships to manage JOBS programs movement in this direction. Could you provide me with information as to how the agency is doing?

Ms. Bane: Due in part to the situation in Lake County, last summer the Administration for Children and Families (ACF) established a new advisory group to address the question of private funding, particularly in the JOBS and Foster Care programs. The purpose of the group was to establish a consistent policy across ACF's programs that would allow us to benefit more from private sources of social service funding without abrogating the protection from abuse that the law affords. The group is still analyzing several options and intends to get input from State/local representatives before proposing new rules.

Mr. Riggs: Because the crux of this entire issue was the technical definition of the term "donation" under existing appropriation law, (at least that was the final reason for denial that was given), in your opinion, would changing the current definition of "donation" what is and is not considered a donation be a possible solution to this problem?

Ms. Bane: We do not believe the problem in the case of Lake County's JOBS contract amounts to a restrictive technical definition of the term "donation" under existing appropriation law. It is true that appropriation law does not consider the exchange between the contractor and Lake County as a donation but rather as an offset or rebate; however, changing that definition would not necessarily make the funds allowable as the State's share for federal matching purposes. Conversely, such a change could open the door to dramatic and possibly harmful results in many other programs.

The JOBS regulations provide for the use of privately-donated funds in the State's share of expenditures, but only under certain conditions. We included those qualifications to ensure the good stewardship of public funds and protect the program from fiscal abuse. I am committed to fostering partnerships within the bounds of those reasonable and important protections.

Mr. Riggs: Why would your agency actively seek to discourage such innovative and effective JOBS programs that make prudent use of taxpayer dollars and improve services for their clients rather than find a way to encourage this type of creative financing in our counties?

Ms. Bane: HHS actively encourages the use of private sector partnerships. The JOBS program in particular encourages collaboration at many levels and in all sectors of the community. JOBS allows for private donations, with caveats regarding the use of those donated funds. Because we see the value in private partnerships that you advocate, ACF has convened an advisory group to foster partnerships, but in a way that makes sense and avoids any risk to the fiscal integrity of the JOBS program.

WELFARE REFORM WAIVERS

Mr. Stokes: Will you give us an assessment of where we are with respect to the issuance of welfare reform waivers, how many have been approved, how many are under consideration, and how many additional requests are expected to come in.

Ms. Bane: This Administration has approved 61 welfare reform demonstration applications from 38 states. Currently, 22 requests from 14 states are pending. It is difficult to predict how many additional requests are expected to come in, but we are aware of more than a dozen additional waiver applications that are expected in the near future.

Mr. Stokes: Can you give an assessment of the strengths and weaknesses of those reviewed so far?

Ms. Bane: Most requests propose broad-based initiatives whose overall features emphasize the very important goals of moving people from welfare to work, and promoting self-sufficiency and parental responsibility. However, in reaching final agreement on projects, we must work out certain aspects with States to assure that adequate protections are maintained, including: assuring that individuals who play by the rules are not penalized; that Medicaid coverage is maintained; and that rigorous evaluation is carried out that will allow us to learn about the impacts of the reforms on employment and earnings, benefit receipt, and child-well being.

Mr. Stokes: What provisions have been built into waivers to insure that they are not just budget cutting mechanisms?

Ms. Bane: The Secretary has adhered to the requirement in section 1115 of the Social Security Act that such waivers, in her judgment, are likely to assist in promoting the objectives of titles XIX and part A and D of title IV applicable to the Medicaid, Aid to Families with Dependent Children and Child Support Enforcement programs. Contrary to what might be a common perception, most welfare reform proposals are not clear cost cutters, but a mix of individual provisions that restructure expenditures towards more primary objectives such as moving recipients from welfare to work. Anticipated gross savings from tougher work and training requirements are typically offset by higher expenditures for child care or increased income disregards and resource limits used as a further incentive to work.

RESPONSIBLE FATHERHOOD

Mr. Stokes: What provisions and funding levels are included in the FY 1997 budget request that would allow the agency to strengthen its responsible fatherhood initiatives?

Ms. Bane: We have requested \$10 million for our FY 1997 Social Services Research Program budget. Once we know what our actual FY 1997 budget is for this program, we can determine funding priorities and consider how to continue developing our responsible fatherhood efforts.

Mr. Stokes: Would you highlight some of the major responsible fatherhood initiatives that are underway at ACF and what specifically they are designed to accomplish?

Ms. Bane: In September 1995, ACF awarded five grants of \$85,000 each to five programs designed to encourage and increase basic responsible acts among fathers, such as establishing paternity and encouraging contact between fathers and children. The five grantees are the Addison County Parent/Child Center in Middlebury, Vermont; Wishard Memorial Hospital in Indianapolis, Indiana; St. Bernardine's Head Start in Baltimore, Maryland; and the Institute for Responsible Fatherhood and Family Revitalization in Washington, D.C., and San Diego, California. ACF's purpose was to fund a group of programs which together engage men at various settings to help develop for the public a better understanding about how to structure programs and services for fathers. More specifically, ACF hopes to learn how these programs may be evaluated properly.

To inform our learning about how to better serve fathers and families, ACF, in cooperation with the Assistant Secretary for Planning and Evaluation, has funded a contract with the Children, Youth, and Family Consortium of the University of Minnesota to undertake a project to increase our understanding of the relationship between responsible fatherhood and child and family well-being. The research will focus on developing a theoretical underpinning to guide empirical research, program development, and program evaluation.

ACF continues its partnership with the DHHS Office of Assistant Secretary for Planning and Evaluation (ASPE), the Department of Labor (DOL) and the Department of Agriculture (USDA), several private foundations, and the Manpower Demonstration Research Corporation to support the Parents' Fair Share (PFS) demonstration and evaluation. PFS is designed to test the effectiveness of employment and training services, peer support, enhanced child support enforcement and mediation services for unemployed noncustodial parents whose children receive AFDC.

Through the welfare reform demonstration process, ACF may allow State welfare agencies to serve unemployed non-custodial fathers in their Job Opportunities and Basic Skills training (JOBS) programs, as in the PFS demonstration. Fifteen states have received demonstration waivers under section 1115 of the

Social Security Act to provide JOBS services to non-custodial fathers of AFDC children. The Department has published guidance, in response to the President's directive, announcing that it would approve non-custodial parent training demonstrations within 30 days of application.

In late February the Child Care Bureau sponsored a national forum on "Family Centered Child Care". Some 300 people participated including State Child Care Administrators, child care providers, parents, and national organizations. One of the three topics covered were approaches to increasing fathers participation in the care of their children. Recommendations for action at the State level will be published and disseminated to State Child Care Administrators and providers on changes in policy, practice, and attitudes that will support fathers involvement in early child care.

On May 3, Child Care Bureau presented a workshop on "Fathers in Early Child Care" at the Vice President's "Federal Conference on Strengthening the Role of Fathers in Families". The workshop provided practical information on how to get fathers interactions, and how to create specific strategies that increase opportunities for father involvement.

Mr. Stokes: How does the FY 1997 budget request for such initiatives compare with the FY 1996 and 1995 funding level?

Ms. Bane: In FY 1995 we contributed \$1.6 million to the PFS evaluation in partnership with ASPE, DOL and USDA. Also, we provided \$500,000 for the five responsible fatherhood grants and the contract with the University of Minnesota. We received 149 responsible fatherhood applications. We were able to fund only 5 of 30 very highly rated proposals. Because the Social Services Research Program was not funded in FY 1996, we were unable to continue funding any of these projects.

HEAD START

Mr. Stokes: According to the Congressional justification, the FY 1997 budget request will allow Head Start to provide services to approximately 40,000 additional children. How many would still be going unserved?

Ms. Bane: According to Census Bureau estimates, there are approximately 2 million low-income children living in this country who are either 3 or 4 years old. During the 1995 program year, Head Start served 750,696 children, 89 percent of whom were aged 3 or 4. While we do not believe that every family, if offered the opportunity, would necessarily send their child to Head Start, there are clearly many hundreds of thousands of 3 and 4 year old children who are eligible for the Head Start program, but are currently unserved. There are, also, of course, many children younger than age 3 who live in families with incomes below the poverty line. While these children have not historically been considered part of Head Start's primary constituency, the growing interest in serving infant

and toddler age children, as evidenced by the Congress including language in the most recent Head Start reauthorization bill to establish the Early Head Start program, would suggest that some number of the eligible under 3 population should also be served in a "fully funded" Head Start program.

Mr. Stokes: Since the evaluation, what major improvements have been made in the Head Start program to help ensure that all participating children get the maximum benefit from the program.

Ms. Bane: When this Administration assumed office, one of our concerns was addressing what we believed to be the uneven quality levels of Head Start programs. While many programs were providing high quality services to children and families, other programs were not always fulfilling all of their obligations as Head Start providers. To address these concerns, we adopted a two pronged approach: to invest funds in improving Head Start quality and to insist that all grantees provide high quality services or be replaced by another agency which will.

Between FY 1992 and FY 1995, we invested almost \$490 million in Head Start quality improvement. These funds have enabled programs to make important quality enhancements such as hiring additional needed staff to allow programs to better meet the needs of their enrolled families; improving the quality of Head Start facilities; improving staff salaries, which in the past had often been very low, to levels which allow Head Start programs to attract and retain quality staff; and purchasing needed classroom supplies and equipment. These investments have worked, and quality levels in Head Start have improved.

However, in allocating grantees quality money, we were clear that all Head Start programs must be held accountable and must provide high quality services. Those grantees unable or unwilling to do so will be replaced by new agencies which can assure that high quality Head Start services will be provided to all enrolled children and families. Efforts to replace these poorly performing programs have increased in recent years. While a small number of programs were discontinued as Head Start grantees because of quality problems during the 30 year history of the program, since October 1993 40 Head Start grantees have been terminated or have relinquished their Head Start grants. During the same time period, approximately 100 other grantees, who had been identified as having serious quality problems, have, with HHS assistance, improved their programs and are now providing quality Head Start services to their communities. Moreover, recent statutory changes help assure grantee accountability. In 1994, the Administration led bipartisan Congressional efforts to reauthorize Head Start and to address program quality and performance. New legislative provisions, such as the requirement that any Head Start grantee with a program deficiency must correct that deficiency within a prescribed time period, not to exceed one year, or face termination proceedings, have been of significant help in allowing the Department to ensure that all Head Start programs provide high quality services.

STATE OF CHILDREN

Mr. Stokes: As you recall, during the FY 1996 budget process, children were among those hardest hit by the cuts and provisions being considered at that time. Now, that the FY 1996 budget has been completed, what assessment can you give regarding its impact on the state of children, with regard to the major programs under the purview of your agency? For the record, a more detailed response is requested.

Ms. Bane: The FY 1996 budget did have an impact on our ability to address the needs of some of the most vulnerable subpopulations of children, youth and families in this country. Particularly affected were children and families in the child welfare system and high-risk youth and their families. In the area of child welfare services, funds for Child Welfare Research and Demonstration and Section 1110 Social Services Research were zeroed out; funds for Child Welfare Training were reduced by more than one-half; and funds for Child Welfare Services, Community-Based Family Resource Program and Child Abuse Discretionary Activities were reduced. We believe that support for these programs is crucial to our ability to define more effective ways to assure that children are protected, families are strengthened and children are assured permanent homes, as well as our ability to assist States in fielding expert workers in their child welfare agencies.

In the youth arena, funding for the Drug Abuse Education and Prevention Program for Runaway and Homeless Youth, the Youth Gang Drug Prevention Program and the Community Schools Program was eliminated. These programs were significant contributors in their communities toward efforts to meet the challenges of youth at highest risk.

Given the reductions in or elimination of these critical programs in FY 1996, it is particularly important that the Congress act favorably on the President's request to restore funding and consolidate both child welfare programs and programs for runaway, homeless and street youth in FY 1997. The proposed Child Welfare Innovative Program would consolidate Child Welfare Training, Research and Demonstration, Adoption Opportunities and Child Abuse Discretionary Activities; and the proposed Comprehensive Runaway and Homeless Youth Services Program would consolidate the Runaway and Homeless Youth Program, the Drug Abuse Education and Prevention Program for Runaway and Homeless Youth, and the Transitional Living Program for Homeless Youth. The enactment of these two consolidated programs would enable States and communities to more responsively address the needs of children, youth and families.

LIHEAP

Mr. Stokes: According to the Congressional Justification, approximately 21 percent of LIHEAP recipients are "working poor" or elderly, who do not receive any other public assistance. What is the impact of the final FY 1996 action on the number served by LIHEAP, and what is the situation under the FY 1997 budget request?

Ms. Bane: The \$900 million in regular block grant funds appropriated for FY 1996 represents about a 1/3 cut from the FY 1995 funding level. The Administration is requesting \$1.0 billion for FY 1997.

We cannot say precisely what the effect would be of a specific percentage reduction in LIHEAP funding, because the States have a great deal of flexibility in designing their own programs. For example, a State could reduce the number of households it serves, but leave benefits the same; continue to serve the same number of households but cut benefit levels; or do a combination of the two.

TEEN PREGNANCY INITIATIVE

Mr. Stokes: The FY 1997 budget request includes \$30 million for a teen pregnancy initiative. What is the extent of the teen pregnancy problem in the U.S. and how does it compare to other countries?

Ms. Bane: The teen birth rate in the U.S. is almost twice as high as the next highest Western industrialized nation. Below are comparative data on teen birth rates:

Country	Births per 1000 females 15-19	
U.S.		60
Great Britain	32	
Canada		26
Norway		15
France		9
Netherlands	5	

Mr. Stokes: What is the profile of the expectant teen, and that of the expectant father?

Ms. Bane: More than half a million U.S. teenagers gave birth in 1993, the latest year for which national statistics are available. Of the 513,647 births to teenagers, 40 percent were to girls under age 18. A decade earlier, there were 499,038 births to teenagers of whom 37 percent were to girls under 18.

The teenage birth rate in 1993 was 59.6 births per 1,000 women aged 15-19, 4 percent lower than in 1991 (62.1), when it was higher than in any year since 1971 (64.5). Teenage birth rates are highest for black and Hispanic teenagers (108.6 and 106.8 per 1,000, respectively), followed by American Indian teenagers (83.1), and lower for non-Hispanic white teenagers (40.7 per 1,000) and Asian or Pacific Islander teenagers (27.0 per 1,000). These patterns have been observed for a number of years.

In 1993, 72 percent of all teenagers giving birth were unmarried; among those under 18 the proportion unmarried was 81 percent. The comparable figures for 1983 were 54 percent unmarried for all births to teenagers, and 69 percent for births to teenagers under age 18.

The birth rate for unmarried teenagers was 44.5 births per 1,000 unmarried women aged 15-19 in 1993, essentially unchanged since 1991, but 51 percent above the rate in 1983 (29.5). The rate for unmarried teenagers aged 15-17 was 30.6 per 1,000 in 1993, about the same as in 1991 and 1992, but 39 percent higher than in 1983 (22.0). The rate for older unmarried teenagers (18-19), 66.9 in 1993, was 64 percent higher than in 1983 (40.7). Although the rates are much higher for black than for white unmarried teenagers, increases in rates for unmarried teenagers between 1983 and 1993 have been much greater for white teenagers--up 80 percent on average--compared with black teenagers--up about 20 percent.

In 1991, the latest year for which complete statistics are available, there were an estimated one million pregnancies among teenagers. The pregnancy rate was 115.0 per 1,000 teenagers aged 15-19. Fifty four percent of these pregnancies resulted in a live birth, 33 percent in a legally induced abortion, and 13 percent in fetal loss.

When attention first began to focus on the fathers of infants born to teenage mothers, it was assumed that they themselves were teenagers. The Department of Health and Human Services collects some data on the fathers of these infants. What data are collected on fathers are reported by the mother and recorded on the birth certificates. These data are typically incomplete.

The Alan Guttmacher Institute (AGI) released a study last year on the role that adult males play in teenage births using birth certificates as well as data from the National Maternal and Infant Health Survey which was conducted from 1989 to 1991. The study found, in 1988, that at least one-half of infants born to teenage girls were fathered by adults. Results of the AGI study show that, in general, the younger the mother, the greater the age difference between her and the infant's father; teenage mothers are more likely than older mothers to have a partner at least several years older. More than one-half of teenage mothers have a partner three or more years older; about 20 percent of teenage mothers have a partner six or more years older.

Mr. Stokes: What are the major features of the proposed teen pregnancy initiative, and specifically, to what extent will communities be allowed to design a program or project that works best for them?

Ms. Bane: The teen pregnancy initiative builds on the Department's ongoing partnership with local communities. It will help communities with high rates of teen pregnancy and an appropriate infrastructure (from which to effectively launch and implement proposed strategies) to move their interventions to the next level of effectiveness. We intend to take what we have learned through a recent, exhaustive review of the research and the literature and use it to advance practice in the field. Communities participating in this initiative will be designing their own interventions, based on local needs and with the guidance of research.

Therefore, a broad range of uses of the funds will be authorized with special priority on those that have been shown, through research, to have a positive effect on youth development and, therefore, on teenage pregnancy reduction.

In addition, in developing the criteria for selection of projects as well as the selection process itself, the Department will seek input from community-based organizations, as well as other groups and individuals working in the field.

HEAD START PROFILE

Mr. Stokes: How would you describe the profile of the average Head Start participant?

Ms. Bane: The typical Head Start child is a 3 or 4 year old pre-schooler from a low-income family (4 percent of Head Start children are under age 3). His or her family is often the poorest of the poor, with 64 percent of Head Start families making less than \$9,000 per year. Half of the Head Start families are AFDC recipients and about 7 in 10 Head Start children are enrolled in Medicaid/EPSDT. Most Head Start children are from minority families -- 36 percent are Black, 25 percent Hispanic, almost 4 percent American Indian and 3 percent Asian. Slightly less than 33 percent of Head Start children are White. Most children are from single family households -- 55 percent of Head Start children are from one parent households, while 41 percent are from two parent households. Approximately one-third of all Head Start heads of household are employed full-time, while another 15 percent are employed part-time or seasonally. In summary, all Head Start children are among this nation's most disadvantaged population -- young children trying to grow up in an environment of "want," while also experiencing problems pervasive in many low-income communities such as substance abuse, child abuse and violence.

Mr. Stokes: How many children are currently served by Head Start?

Ms. Bane: In FY 1996, we estimate that almost 757,000 children will be served by Head Start.

Mr. Stokes: How many and what percentage of Head Start children and their families have health insurance coverage?

Ms. Bane: We do not have data on the number of families which have private health insurance. Approximately 70 percent of the Head Start families are enrolled in Medicaid/EPSDT.

Mr. Stokes: Who tends to be the provider of health care services to Head Start children and their families?

Ms. Bane: Head Start programs must assure that all enrolled children receive complete medical and dental services, including screenings, treatment and immunizations. These services are typically provided by a pediatrician in the community in which the Head Start program is operating. We do not have data on who is the typical health care provider of Head Start parents.

CHILD CARE

Mr. Stokes: There is increasing public and congressional concern and awareness about the importance of child care for working families. Two of the most recent reports on the matter, the National Institute on Child Health and Development report which addresses maternal attachment, and the Census report which addresses child care arrangements, have brought renewed attention to the child care issue. How much is included in the FY 1997 budget request for the Child Care and Development Block Grant, and how does this compare with FY 1996, FY 1995, and FY 1994? For each of the years indicated, what was the impact on the increase, decrease, or flat funding on the people served by the program?

Ms. Bane: The Clinton Administration has requested increases in the CCDBG each year and is requesting an increase of \$114 million for FY 1997. In general, the appropriations for CCDBG over the past 4 years have remained relatively flat, with the only increase coming in FY 95. States plan their programs very carefully to try to avoid decreases in services to children, even if the state allocation does not keep pace with rising child care costs.

	<u>Request</u>	<u>Appropriation</u>
FY 1993	\$ 850,000,000	\$892,711,000
FY 1994	\$ 958,964,000	\$892,641,000
FY 1995	\$1,090,662,000	\$934,642,000
FY 1996	\$1,048,825,000	\$934,642,000
FY 1997	\$1,048,825,000	

Mr. Stokes: How critical is this program to keeping families working and supporting children's healthy development?

Ms. Bane: Child care is absolutely essential for working families and parents attending school or training. Families need high quality care so that they can work knowing that their children are safe and well cared for.

We have much evidence that child care assistance helps to keep people working; the GAO estimated that child care subsidies could increase work among poor women by 52 percent. Similarly we know that families without child care often turn to welfare. In Milwaukee, Wisconsin, approximately one fourth of all families who exhausted their Transitional Child Care benefits between October 1992-November 1993 returned to AFDC. The Greater Minneapolis Day Care Association surveyed families on their child care waiting list and found that: One-quarter of the families on the waiting list turned to AFDC for economic survival; the short-term cost of supporting families on welfare was \$595 more per month per family than the cost of supporting a similar family with only child care subsidies; and many families incurred overwhelming debt as a result of their child care expenses. Seventy-one percent fell into debt and 47 percent depleted their savings.

The CCDBG program is truly important to the promotion of children's healthy development. The "Cost, Quality and Outcomes for Children" study found children's cognitive and social development to be positively related to the quality of their child care center. Children in higher quality programs displayed higher language and pre-math ability and social skills. The literature that examines the effects of quality of child care is beginning to suggest that quality, structure and appropriate adult supervision may matter more for low-income children than for their higher-income peers. Because low-income families face more significant constraints in choice of child care, the support available through CCDBG can provide important opportunities for children to receive developmentally appropriate, high-quality care.

HEAD START

Mr. Stokes: In previous years, proposed increases for Head Start have been invested in program expansion, and for program improvements. How much is included in the FY 1997 budget request for Head Start, and how does it compare with FY 1996, FY 1995, and FY 1994? For FY 1997, what is the primary purpose for the FY 1997 increase for the Head Start Program?

Ms. Bane: The FY 1997 request for Head Start is \$3.981 billion, an increase of \$411 million over FY 1996. The FY 1996 request submitted by President Clinton proposed a \$400 million funding increase, the FY 1995 request a \$700 million increase and the FY 1994 request a \$874 million increase.

FY 1997's proposed funding increase will be used for the following four purposes: (1) to award all grantees a statutorily mandated cost-of-living increase (\$96 million); (2) to award grantees quality improvement funds as mandated under the statute (\$78 million); (3) to improve the Head Start training and technical assistance system (\$8 million); and (4) to increase enrollment to 800,000 children and families (\$229 million).

EARLY HEAD START

Mr. Stokes: I understand that the agency awarded the first round of Early Head Start grants last year. How many grants were awarded, and what was the average cost of the grants?

Ms. Bane: Sixty-eight grants were awarded. The average grant award was approximately \$700,000.

Mr. Stokes: What is the total amount of funds set aside for Early Head Start grants?

Ms. Bane: The Head Start Act requires that, in FY 1996, 4 percent of the total Head Start appropriation, or \$142.8 million, be set aside for Early Head Start.

Mr. Stokes: When will the next round of grants be awarded, and what is the projected number of awards for that round?

Ms. Bane: Prior to the end of FY 1996, ACF will award another round of Early Head Start grants. We estimate that between 55 to 75 new Early Head Start providers will be funded.

Mr. Stokes: For the record, would you elaborate on the importance of the Early Head Start program?

Ms. Bane: Findings from more than three decades of research in child and family development support the vision and goals of the Early Head Start program. We know that the time from conception to age three is a critical period of human development, as changes occur more rapidly during this period than in any other period of life. Growth in these years establishes the basic foundation for future development. For infants and toddlers to develop well, they must have healthy beginnings and they must have a continuity of responsive and caring relationships which promote optimal cognitive, social, emotional, physical and language development. When these supports are missing, the immediate and future development of a child may be compromised.

CHILD WELFARE

Mr. Stokes: For child welfare programs, the Agency's FY 1997 budget request proposes the consolidation of two programs into the Community-Based Family Resource Centers Program, and the consolidation of four discretionary programs into a Child Welfare Innovations fund. Explain, how these two major proposals are in the best interest of the people served by these programs?

Ms. Bane: The Community-Based Family Resource Program was authorized by the Congress in the Human Services Amendments of 1994 through the consolidation of several smaller programs focused on child abuse prevention and family resource and support services. The consolidation of these programs reflected a desire on the part of the Congress to provide States and communities with a flexible funding source that could be used to fund a variety of preventive and support services that best meet the needs of families in individual communities. The Administration's proposal to consolidate two additional programs, the Temporary Child Care and Crisis Nurseries program and the McKinney Family Support Center program, is in keeping with this philosophy and with the Administration's own desire to enable States and communities to provide more comprehensive, integrated and responsive services by reducing, when appropriate, the number of narrowly focused categorical programs.

The proposed Child Welfare Innovative Program is a consolidation of four previously freestanding, more narrowly focused programs: Child Welfare Training, Child Welfare Research and Demonstration, Adoption Opportunities and Child Abuse Discretionary Grants. These four discretionary programs were intended not only to serve children and families, but also to assist in the design of new and innovative ways to deliver services to underserved populations. The new Child Welfare Innovative Program will provide more flexibility than is currently possible. Programmatic priorities in each of these areas will be able to be established based on critical and emerging needs. This flexibility is necessary and appropriate at a time when reports of child abuse and neglect keep growing and the number of children entering foster care continues to grow without a concomitant increase in Federal and State funds. This program will give us the capacity to develop and evaluate new and better ways of addressing the needs of children and families and will improve our ability to take a more systemic approach to program improvement.

Mr. Stokes: To what extent will the number of people served increase or decrease?

Ms. Bane: These dollars are used to develop new knowledge and to test new service delivery strategies. They are not service delivery dollars in the usual sense. It is difficult to project the number of people who would be served under the demonstrations. However, the lessons learned from the innovation and research and demonstration projects will impact services nationally and our efforts to make these services more efficient.

Mr. Stokes: How much is included in the FY 1997 budget request for each of these two major consolidated programs? Provide for the record a list of the programs proposed for consolidation under each consolidation cluster, the amount included in the FY 1996, FY 1995 and FY 1994 [sic] for each of these individual programs, and proposed aggregated amount for FY 1997?

Ms. Bane: Community-Based Family Resource Centers Program
 Aggregated amount for FY 1997 \$50,569,000

Community-Based Family Resource Program

FY 1994	Did not exist
FY 1995	\$31,363,000
FY 1996	\$23,000,000

Temporary Child Care and Crisis Nurseries

FY 1994	\$11,912,000
FY 1995	\$11,835,000
FY 1996	\$ 9,835,000

McKinney Act Family Support Center Program

FY 1994	\$ 6,874,000
FY 1995	\$ 7,371,000
FY 1996	\$ -0-

Child Welfare Innovative Program

Aggregated amount for FY 1997 \$39,178,336

Child Welfare Training

FY 1994	\$ 4,439,000
FY 1995	\$ 4,398,087
FY 1996	\$ 2,000,000

Child Welfare Research and Demonstration

FY 1994	\$ 6,466,000
FY 1995	\$ 6,394,684
FY 1996	\$ -0-

Adoption Opportunities

FY 1994	\$12,117,000
FY 1995	\$13,000,330
FY 1996	\$11,000,000

Child Abuse Discretionary Grants

FY 1994	\$15,577,000
FY 1995	\$15,385,235
FY 1996	\$14,154,000

Mr. Stokes: Given the current status of State child welfare systems around the country, how does the agency's proposed approach contrast with the approach resulting from the FY 1996 appropriations process.

Ms. Bane: The 1996 process reduced available funding, zeroed out our most flexible source of funds, and reduced training grants by 54 percent. It gave no flexibility for the redistribution of funds among the programs and no ability to distribute funds according to program initiatives or actual need.

SOCIAL SERVICE RESEARCH

Mr. Stokes: As the nation seeks to dramatically reform its welfare system, how important is Social Services Research to helping to ensure that recommended approaches are workable?

Ms. Bane: Social services research is the Department's primary tool to further knowledge and develop information which is essential in assisting states to effectively reform and implement their welfare systems. Well controlled cross-site studies are essential for testing, evaluating and developing good understandings of what does or does not work and why. It is also important to build on carefully done recent studies, the early results of which have been critical to national and state decision makers--in increasing employment of low-income families, improving child support, and in promoting responsible parenthood.

Mr. Stokes: How much is included in the FY 1997 budget request for this activity, and how does it compare with FY 1996, and FY 1995?

Ms. Bane: For this activity, we have asked for \$10,000,000 in the FY 1997 budget request. No funds were appropriated for this activity in FY 1996; in FY 1995, \$14,815,894 was appropriated.

Mr. Stokes: How critical is this program to the agency's ability to promote personal responsibility, work, and child well-being, and what was the impact of the FY 1996 budget action on these initiatives individually, and collectively?

Ms. Bane: This program is very critical to the agency's ability to formulate and implement informed policy decisions and to work with states to promote personal responsibility, work and child well-being. The 1996 budget action which did not provide any funds for this activity meant that a number of long-term evaluation and promising intervention projects were threatened, curtailed, or eliminated. For example, ACF was unable to continue funding support for--

- the JOBS EVALUATION, a major national evaluation, currently reporting useful findings on critical design elements in welfare to work programs, such as that mandatory work programs (GA, MI, CA) offering services for rapid job entry produced dramatic reductions in the numbers on AFDC

(-16%), decreases on AFDC payments (-22%), and increases in employment and earnings (+22%);

- Parents Fair Share, a project reporting that work and training requirements for non-custodial parents owing child support had identified ("smoked out") 25% of such parents as already working; or
- a long-term evaluation project and follow-up for a Nurse Visitation project which reduced subsequent pregnancies among young, primarily unwed mothers by 25%.

Nor, were we able to fund any new Responsible Fatherhood projects. In 1995, we received 149 Responsible Fatherhood applications. But, we were able to fund only 5 of 30 very highly rated proposals.

CHILD CARE

Mr. Hoyer: As more parents go to work, the importance of child care -- and of child care quality -- increases. I am pleased to see that the administration is requesting a \$114 million increase in the Child Care and Development Block Grant. I know that 5% of block grant funds are reserved for quality improvement activities and for before and after school activities. How big are the waiting lists for child care assistance now?

Ms. Bane: Actually, based on our authorizing legislation for the Child Care and Development Block Grant, each state must reserve 25 percent of the block grant funds for activities designed to improve the quality of child care and to provide before- and after-school and early childhood development services.

The number of low-income families seeking child care greatly outstrips existing resources across the country. Based on reports from our regional offices, we estimate that over half of the states maintain waiting lists for child care subsidies. The General Accounting Office noted lengthy waiting lists for working poor families in its May 1994 report to the Committee on Education and Labor. Five out of six sites they visited had waiting lists.

The Department does not routinely collect waiting list information in state plans or reporting forms. However, the Assistant Secretary for Planning and Evaluation recently conducted a survey with the Urban Institute: "Child Care Prices: A Profile of Six Communities, Draft Report January 1995":

Birmingham, Alabama: 5,000 low-income working families are waiting to receive a subsidy. On average, these families will wait about 19 months.

Dallas, Texas: 2,100 income-eligible children are on a waiting list for subsidy; last year only 600 children on that list were able to receive certificates.

Chicago, Illinois: The At-Risk Child Care (ARCC) subsidy program was frozen in August 1993; about 700 families leaving the Transitional Child Care (TCC) program have been added to the ARCC waiting list each month. The State Department of Children and Family Services office also has a waiting list of 10,000 families for CCDBG and Title XX funds.

San Francisco, California: The average wait for child care subsidies varies from 6 months to 5 years, and frequently a child ages out of the program by the time funds are available. The longest wait is for low-income working families.

Mr. Hoyer: How many additional children will be served with this increase? How many of them are in the 0-3 age group?

Ms. Bane: In his FY 97 budget request, the President proposed \$1.049

billion for the CCDBG, an increase of \$114 million or 12 percent over FY 96, which will serve an estimated 70,000 additional children.

Based on 41 States/Territories reporting the ages of children served in fiscal year 1993, we estimate that 39 percent of children served with CCDBG funds are in the 0-3 age group. We assume states will continue to spend at least that proportion of funds on infants and toddlers due to the growing demand for safe and affordable child care for this age group.

Mr. Hoyer: Can you tell the Committee how much was spent on quality improvement last year?

Ms. Bane: Total expenditures on quality under both the 75 and 25 percent funds for the 1993 reporting period totaled \$66,470,571.

Mr. Hoyer: What are the most common quality improvement activities?

Ms. Bane: The following percentages by service type were reported by grantees:

Child Care Resource and Referral	30%
Monitoring and Licensing of Providers	29%
Training and Technical Assistance	23%
Improvement of Standards	13%
Other Authorized Activities	5%
Improving Staff Compensation	1%

Data for 1994 are being analyzed and 1995 data are now being collected.

Mr. Hoyer: How do you track the effectiveness of these efforts, which are run by the states? How does ACF help to disseminate information about practices which contribute to quality in the states?

Ms. Bane: The Child Care and Development Block Grant statute does not provide authority or funding for formal evaluation of the CCDBG program. However, States, tribes and territories monitor their activities and, as required by statute, ACF gathers information about the program from grantees which is used to compile the Annual Report to Congress.

The GAO in its December 1994 report, "Promoting Quality and Family Child Care", found that "the most frequently used source of federal funds to support quality and enhancement initiatives in family child care was the CCDBG."

The National Child Care Information Center routinely compiles information on a variety of quality activities and services reported by the States. Additionally, the Child Care Bureau promotes quality improvement activities through regular communication with grantees and the child care community. In 1995, in addition to our national State and Tribal child care conferences and regional meetings, we

held a National Child Care Health Forum through which we launched the Healthy Child Care America Campaign, a nationwide effort by health care and child care providers to improve the health and safety of children and families. Using the Blueprint for Action developed at the Forum, States and communities all over the country can make linkages between health programs and child care. We also held a national leadership forum "Including Children with Disabilities in Child Care Settings: Connections for Quality Care" in which national leaders addressed the development of an inclusive child care system for children with disabilities and shared strategies and models which can be adapted by States, Territories and Tribes. A monograph "Passages to Inclusion: Creating Systems of Care for All Children" will provide guidance for the development of effective, efficient systems.

In 1996, we held a similar leadership forum promoting family-centered child care to develop guidelines for State, territorial, and tribal administrators, parents, and child care providers to effectively communicate with, support, and involve families in full-day child care programs.

In addition, ACF promotes quality comprehensive services and public awareness through a bi-monthly Child Care Bulletin that is distributed to over 1500 individuals and organizations and is available electronically on the World Wide Web and at a gopher site. The Bulletin highlights timely ideas and information to improve child care systems, program operations, and child care quality, and to expand child care services.

LIHEAP

Mr. Hoyer: This was an extremely difficult winter, and early signs are that it may be a particularly hot and dry summer in many parts of the country. Did you have higher than normal reliance on LIHEAP assistance last winter?

Ms. Bane: We do not yet have data on the number of households served in the winter of 1995-1996.

Mr. Hoyer: Do you have adequate funds available for this summer, for cooling assistance which is particularly important to preserve the health of our very old and very young?

Ms. Bane: All of the regular LIHEAP block grant funds for FY 1996 have been distributed to grantees. In addition, \$180 million in emergency contingency funds were distributed to all LIHEAP grantees under the regular block grant allocation formula on April 11, because of the unusually long, cold winter. Very few States normally run a cooling assistance program, but States could use some of these LIHEAP funds for this purpose.

Mr. Hoyer: What will be the impact of the \$319 million cut from 1995 to 1997?

Ms. Bane: We cannot say precisely what the effect will be of a specific percentage reduction in LIHEAP funding, because the States have a great deal of flexibility in designing their own programs. For example, if the funding were reduced, a State could reduce the number of households it serves, but leave benefits the same; continue to serve the same number of households but cut benefit levels; or a combination of the two.

Mr. Hoyer: Will the Residential Energy Assistance Challenge Grant program which you began in 1996 help to address these shortfalls?

Ms. Bane: Under the terms of Public Law 103-252, which authorized the REACH program, we may set aside up to 25% of funds earmarked for the leveraging incentive program to be used for REACH grants. This means that a maximum of \$5,625,000 will be used for REACH grants in FY 1996. Grants awards will be made in September 1996.

CHILD CARE

Ms. Pelosi: Parents and providers continue to be concerned with a lack of supply of infant/toddler care. Even in my district, which has a well-established child care delivery system, we are very short on quality spots for babies. What are your plans to increase the supply of infant care for parents who work full-time and at odd hours?

Ms. Bane: Millions of infants and toddlers across the country are in need of child care while their parents are at work. Yet, according to numerous reports throughout the past year, access to quality infant care remains a serious issue, particularly for low-income working families. We, too, are gravely concerned about the unmet need for safe, healthy, and reliable care for infants and toddlers.

Under the CCDBG we do not have statutory authority to target additional funding to infant/toddler care. However, the Administration's welfare reform proposals have supported and encouraged additional spending for services to infants and toddlers. Currently, several States are using Child Care and Development Block Grant funds to improve infant care.

The Child Care Bureau continuously promotes the expansion of quality infant care through its outreach and technical assistance efforts and collaboration with Head Start and Early Head Start. In addition, in 1994 ACF convened an Infant and Toddler Child Care Institute to examine research, use of unregulated providers, linking health services with child care providers, and programs and services for teen parents. Recently, we devoted an issue of the Child Care Bulletin to promoting quality care for infants and toddlers, including promising examples from the States.

Ms. Pelosi: Since the passage of the Child Care Development Block Grant, there has been a great shift in the use of license-exempt care. In my state, the Trustline program has been put into place to do a background check to ensure that child care providers are not inappropriate. But this is only the basement level of services that can be provided. What are your plans to bring resources, training, and support to these license-exempt arrangements, where parents are averaging 3 to 4 caregivers within six months, and where low-income parents turn in desperation to friends or neighbors who may not be appropriate or quality child care providers?

Ms. Bane: As you know, the Child Care and Development Block Grant statute provides the States wide flexibility in setting standards for care. States decide what kind of licensing requirements they will hold providers accountable to, and which providers will be exempt. CCDBG assures that all care, even license exempt care, must meet basic health and safety requirements as set by the State. The administration has continued to strongly support these provisions and other improvements in the quality of care.

The CCDBG also provides us with one of the only routes towards reaching and offering training and other supports to these providers. The CCDBG reinforces that all providers caring for children funded under this program should take at least minimal precautions in protecting the health and safety of children in their care. Along with this, the Act provided resources that states can use to recruit, train and support providers. Resource and Referral agencies and provider organizations play an important role in this regard by helping to link individual providers to critical resources.

Ms. Pelosi: In the recently passed budget, there was a significant loss for the child care community, a program particularly important to the state of California. The federal Dependent Care Block Grant helps to fund start up school-age child care programs, and is an important piece of the child care resource and referral system. With the loss of this funding, child care resource and referral agencies lose their ability to reach the corners of their communities - to provide outreach to people not otherwise served - low-income parents, non-English speaking parents, parents that need assistance finding child care. How did it happen that this \$13 million was cut? What is the Administration's strategy for restoring funds for child care?

Ms. Bane: The Department proposed consolidation of several programs into the Child Care and Development Block Grant together with their program funds. Our budget proposal for FY 96 included, and our current proposal for FY 97 includes, the funds for these activities in the CCDBG funding proposal. We sincerely hope that the funds to provide critical child care resource and referral and school age services are fully restored.

CHILD ABUSE AND NEGLECT

Ms. Lowey: We all know that the number of reported child abuse and neglect cases has reached staggering proportions. We also know that we need more qualified, trained child welfare workers who are skilled at handling these complex cases. The Administration has proposed the new Innovative Child Welfare Grant Program that would consolidate a number of child welfare discretionary programs, including Child Welfare Training under Title IV-B. With the need for more trained child protective workers, not less, what assurances are there that a portion of these funds will go directly to schools of social work to train child welfare workers, as such funds are now provided under the title IV-B program?

Ms. Bane: We share your concern about the critical need for trained child welfare workers, and are distressed by the FY 1996 cut in the appropriation for Child Welfare Training. Over the years, ACF and the Children's Bureau have been striving to make social work training a high priority. I believe the danger will not be in putting too little into training child welfare workers but, given the great need, how to limit what is put into it (so that funds would be available for other priorities) when the available funds would be as flexible as we propose for the Innovative Child Welfare Grant Program. In recent years, a percentage of title IV-B training funds have been used to push and expand the field of social work education into new and increasingly relevant fields of training for child welfare workers, such as interdisciplinary training and education in the areas of domestic violence and developmental disabilities. Additionally the title IV-E foster care program provides an ongoing funding mechanism which supports the training of child welfare workers in both agencies and in schools of social work.

JUSTIFICATION OF THE BUDGET ESTIMATES

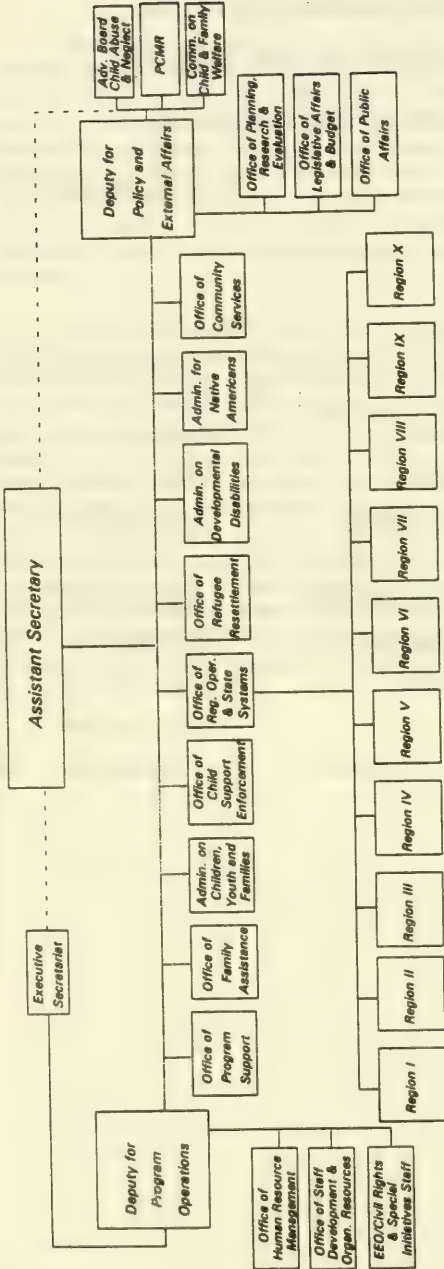
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES

	<u>FY 1997 Estimate</u>	<u>Page</u>
Organizational Chart		A-1
Entitlement Programs		
Family Support Payments to States .	\$18,101,000,000	B-1
Job Opportunities and Basic Skills	1,000,000,000	C-1
Payments to States for Foster Care and Adoption Assistance	4,445,000,000	D-1
Social Services Block Grant	2,800,000,000	E-1
Family Preservation and Support . .	240,000,000	F-1
Discretionary Programs		
Low Income Home Energy Assistance .	1,000,000,000	G-1
Children and Families Services . .	5,251,328,000	H-1
Child Care and Development	1,048,825,000	I-1
Refugee Resettlement	381,536,000	J-1
Violent Crime Reduction Programs .	29,000,000	K-1

Administration for Children and Families

02/96



In his State of the Union message and in the FY 1997 budget the President continues to encourage enactment of a bipartisan welfare reform bill. If a bill is enacted, as proposed by the President in his FY 1997 Budget, the programs in this section of the budget would be affected and the current law numbers that appear would change.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Family Support Payments to States

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation language and explanation of language changes .	B-3
Language Analysis	B-4
Amounts available for obligation	B-5
Summary of changes	B-6
Budget authority by activity	B-9
Budget authority by object	B-11
Authorizing legislation	B-12
Appropriation history table	B-14
Justification:	
A. General Statement	B-17
B. Aid to Families with Dependent Children	B-18
C. Child Support Enforcement	B-31
D. State Tables	B-35

FAMILY SUPPORT PAYMENTS TO STATES

For making payments to States or other non-Federal entities, except as otherwise provided, under titles I, IV-A (other than section 402(g)(6)) and D, X, XI, XIV, and XVI of the Social Security Act, and the Act of July 5, 1960 (24 U.S.C. ch. 9), 13,301,000,000, to remain available until expended.

For making, after May 31 of the current fiscal year, payments to States or other non-Federal entities under titles I, IV-A and D, X, XI, XIV, and XVI of the Social Security Act, for the last three months of the current year for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or other non-Federal entities under titles I, IV-A, (other than section 402(g)(6)) and D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch. 9) for the first quarter of fiscal year 1998, \$4,700,000,000, to remain available until expended.

Note. - A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

Language Analysis

Language Provision

Explanation

"...to remain available until expended..."

This language provides authority to use funds appropriated but not obligated in one fiscal year for obligations and expenditures in subsequent years.

"...under titles I, IV-A (other than section 402(g) (6)..."

Section 402(g) (6) authorizes funds for the Child Care Licensing Improvement Grants program for which no appropriation is requested for FY 1997.

"For making, after May 31 of the current fiscal year, payments to States or other non-Federal entities under titles I, IV-A and D, X, XI, XIV, and XVI of the Social Security Act, for the last three months of the current year for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary."

Provides that Federal matching for unanticipated increases in costs, to which States become entitled during the last 3 months of the current fiscal year, can be funded from an indefinite appropriation in the current year. The indefinite appropriation is available as necessary in addition to the regular appropriation for the current fiscal year.

"For making payments to States or other non-Federal entities under titles I, IV-A (other than section 402 (g) (6)) and D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch. 9) for the first quarter of fiscal year 1998, \$4,700,000,000, to remain available until expended."

This language provides for an advance appropriation of funds for the first quarter of fiscal year 1998. This ensures that welfare payments by States will not be delayed at the beginning of a fiscal year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES
FAMILY SUPPORT PAYMENTS TO STATES

Amounts Available for Obligation

	1995 Actual Appropriation	1996 Policy "	1997 Estimate
Appropriation:			
Annual (definite)	\$12,761,788,000	\$12,693,826,000	\$13,301,000,000
Permanent	4,200,000,000	4,400,000,000	4,800,000,000
Annual (indefinite)	529,297,000		
Subtotal, budget authority	\$17,491,085,000	\$17,093,826,000	\$18,101,000,000
Unobligated balance, start of year	37,146,000	105,374,000	
Unobligated balance, end of year	-105,374,000	0	0
Total, obligations	\$17,422,857,000	\$17,199,200,000	\$18,101,000,000

" Based on levels of the ninth CR, including an incremental policy adjustment.

Family Support Payments to States
SUMMARY OF CHANGES

1996 Policy/appropriation	\$17,093,826,000
Total, estimated budget authority	\$17,093,826,000
[Obligations]	[\$17,199,200,000]
1997 Estimate	\$18,101,000,000
[Obligations]	[\$18,101,000,000]
Net change	+\$1,007,174,000
[Obligations]	+\$[901,800,000]

	<u>1996 Current Estimate Base</u>	<u>Change from Base</u>
<u>Increases:</u>		
A. <u>Built-in:</u>		
1. AFDC Payments:.....	\$11,275,626,000	
a. Increases in State AFDC average payments		+ \$116,000,000
b. Increases in AFDC caseload from economic and demographic changes		+166,000,000
c. Financial adjustment to offset the absence of unobligated carryover balances in FY 1997.....		+105,374,000
d. Adjustment to reconcile differences between actual expenditures and projections.....		+85,000,000
2. Emergency Assistance:		
Increase due to higher caseloads and average payments.....	1,687,000,000	+180,000,000

3. AFDC and Transitional Child Care: Increase in participation	1,069,000,000	+78,000,000
4. AFDC State Administrative Costs: Increases due to larger caseload and inflation	1,678,900,000	+196,100,000
5. Child Support Enforcement State Administrative Costs:Increases due to greater State enforcement efforts and inflation	1,836,000,000	+259,000,000
6. Increase in CSE incentive payments due to increased collections	429,000,000	+30,000,000
Total increases.....		+1,215,474,000

Decreases:A. Built-In:

- | | |
|--|-------------|
| 1. Reduction in AFDC expenditures due to increases in CSE Collections..... | -84,000,000 |
| 2. Increase in Federal share of AFDC recovered overpayments..... | -5,000,000 |

B. Program:

- | | |
|---|------------------|
| 1. Return to regular State ceiling level for child care available to "at-risk" non-AFDC families: | -35,000,000 |
| 2. Decrease in CSE state administrative costs due to the expiration of 90% ADP match rate at the end of FY 1995.... | -43,000,000 |
| 3. Change in recovery of QC liabilities..... | -11,300,000 |
| 4. Revised matching rate based on Federal Medical Assistance Percentage (FMAP)..... | -30,000,000 |
| Total decreases..... | -\$208,300,000 |
| Net change..... | +\$1,007,174,000 |

Family Support Payments to States
Budget Authority by Activity
(Dollars in thousands)

	1995 Actual Appropriation	1996 Policy "	1997 Estimate
1. MAINTENANCE ASSISTANCE:			
AFDC payments ¹	\$12,181,553	\$11,340,300	\$11,661,000
Payments to Territories	24,862	25,000	25,000
Emergency Assistance	983,736	1,687,000	1,867,000
Repatriation	150	1,000	1,000
AFDC Child Care	655,140	819,602	879,405
Transitional Child Care	199,688	249,398	267,595
At-Risk Child Care	296,709	335,000	300,000
State/Local Welfare Administrative costs	1,779,902	1,678,900	1,875,000
Subtotal, MAINTENANCE ASSISTANCE	16,121,740	16,071,526	16,876,000
2. CHILD SUPPORT ENFORCEMENT:			
Gross Federal share of collections	-1,212,000	-1,282,000	-1,366,000
Incentive payments to states	389,513	429,000	459,000
State & Local Administration ^{2/}	2,123,604	1,916,000	2,132,000
Subtotal, CSE	\$1,301,117	\$1,063,000	\$1,225,000

^{1/} Based on levels of the ninth CR, including an incremental policy adjustment.

^{2/} FY 1997 estimate assumes AFDC payments of \$11,713,000,000 offset by \$52,000,000 in anticipated AFDC Quality Control penalty collections. FY 1996 Policy assumes AFDC payments of \$11,381,000,000 offset by \$40,700,000 in anticipated AFDC Quality Control penalty collections. There were no AFDC Quality Control collections in FY 1995.

Budget Authority by Activity (continued)

	1995	1996	1997
	<u>Actual Appropriation</u>	<u>Policy "</u>	<u>Estimate</u>
Subtotal, obligations	\$17,422,857	\$17,199,000	\$18,101,000
Unobligated Balances:			
Beginning of Year	-37,146	-105,374	0
End of Year	<u>105,374</u>	<u>0</u>	<u>--</u>
Subtotal, net budget authority	\$17,491,085	\$17,093,826	\$18,101,000

Based on levels of the ninth CR, including an incremental policy adjustment.

Family Support Payments to States
Budget Authority by Object

	<u>1996</u> <u>Policy"</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
Grants, subsidies and contributions	\$17,093,826,000	\$18,101,000,000	+\$1,007,174,000
Total, budget authority by object	\$17,093,826,000	\$18,101,000,000	+\$1,007,174,000
Total, obligations	[\$17,199,200,000]	[\$18,101,000,000]	[+\$901,800,000]

" Based on levels of the ninth CR, including an incremental policy adjustment.

Family Support Payments to States

Authorizing Legislation

1996 Amount Authorized	1996 Policy	1997 Amount Authorized	1997 Budget Request
------------------------------	----------------	------------------------------	---------------------------

Family Support Payments:

Titles I, IV-A and -D,
X, XI, XIV and XVI of
the Social Security
Act and the Act of
July 5, 1960 (Public
Law 86-571)

Total

Appropriation.

Indefinite" \$17,093,826,000 Indefinite" \$18,101,000,000

Generally, indefinite authority is authorized for this account; however, there are specific authorizations for a few of the programs covered by this appropriation:

- o Section 1108(a) of the Social Security Act provides for a limitation on payment to Puerto Rico, Guam and the Virgin Islands under titles I, X, XIV, XVI, and under part A of title IV (exclusive of any amounts on account of services and items to which section 1108(b) applies). The limitations, which became permanent with the enactment of Public Law 96-272 and were amended by Section 602 of P.L. 100-485, are as follows: \$82,000,000 for Puerto Rico, \$2,800,000 for the Virgin Islands and \$3,800,000 for Guam. Section 601 of the Family Support Act (P.L. 100-485) provides a limitation of \$1,000,000 for American Samoa.
- o Section 1113 of the Social Security Act provides for a \$1,000,000 limitation on funds paid to repatriated U.S. citizens and dependents who return because of destitution, illness or international crisis.

- o Section 5081 of the Omnibus Budget Reconciliation Act of FY 1990 authorized \$300 million for each fiscal year beginning with fiscal year 1991 for the At-Risk Child Care program. The actual amount obligated for FY 1995 was \$296,709,000. Under the statute, unused ceiling authority in a given year is available to States in the subsequent year, provided certain conditions are met. This extra ceiling authority is reflected in the revised FY 1996 estimate of \$335,000,000. The budget request for FY 1997 is \$300 million, the full amount authorized.

Family Support Payments to States^{1/}

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation/ Policy</u>
1988	10,243,668,000	11,125,000,000	11,125,000,000	11,125,000,000
1989	10,355,137,000	10,355,137,000	10,704,337,000	10,704,337,000
Indefinite				187,683,000
1990	11,171,946,000	11,707,946,000	11,707,946,000	11,707,946,000
Indefinite				475,262,000
Sequester ^{2/}				-18,326,000
1991	12,657,246,000	12,657,246,000	13,172,346,000	13,172,346,000
Indefinite				622,096,000
1992	15,162,146,000	15,162,146,000	15,201,046,000	15,201,046,000
Indefinite				258,840,000
1993	15,441,950,000	15,441,950,000	15,695,072,000	15,695,072,000
1994	15,915,966,000	15,915,966,000	15,915,966,000	15,915,966,000
1995	16,961,788,000	16,961,788,000	16,961,788,000	16,961,788,000
1996	18,014,307,000	18,014,307,000	18,014,307,000 ^{3/}	17,093,826,000
1997	18,101,000,000			
1998 ^{4/}	4,700,000,000			

- 1/ The Family Support Payments account was established in FY 1987 with the creation of the former Family Support Administration.
- 2/ The sequester affected Child Support Enforcement only.
- 3/ Senate Committee Mark
- 4/ This is the first quarter advance appropriation requested for FY 1998.

Justification
Family Support Payments to States

	1996 Policy	1997 Estimate	Increase or Decrease
Benefit Payments:			
AFDC payments ^{1/}	\$11,234,926,000	\$11,661,000,000	+\$426,074,000
Net CSE			
collections...	<u>-853,000,000</u>	<u>-907,000,000</u>	<u>-54,000,000</u>
Subtotal.....	10,381,926,000	10,754,000,000	372,074,000
Payments to			
territories.....	25,000,000	25,000,000	--
Emergency assistance	1,687,000,000	1,867,000,000	+180,000,000
Repatriation.....	1,000,000	1,000,000	--
AFDC child care...	819,602,000	879,405,000	+59,803,000
Trans. child care..	249,398,000	267,595,000	+18,197,000
At-Risk Child Care.	335,000,000	300,000,000	-35,000,000
State/Local AFDC			
administrative			
costs.....	<u>1,678,900,000</u>	<u>1,875,000,000</u>	<u>+196,100,000</u>
Subtotal, AFDC	\$15,177,826,000	\$15,969,000,000	+\$791,174,000
CSE State/Local			
Administrative			
Costs.....	1,916,000,000	2,132,000,000	+216,000,000
Total, budget			
authority.....	\$17,093,826,000	\$18,101,000,000	+\$1,007,174,000
Total,			
obligations....	\$17,199,200,000	\$18,101,000,000	+\$901,800,000

^{1/} The FY 1997 request for AFDC payments of \$11,660,789,000 assumes \$52,000,000 in QC Collections, which offsets gross AFDC Federal payments of \$11,713,000,000.

FAMILY SUPPORT PAYMENTS TO STATES

General Statement

Programs Financed:

Family Support Payments to States support State-administered programs of financial assistance and supportive services for low-income families to promote their economic security and self-sufficiency. The account funds seven basic activities:

- AFDC benefit payments to needy families with children;
- Payments to territories for adult-only benefits to residents of Guam, Puerto Rico, and the Virgin Islands;
- Emergency Assistance benefits and services to families with children to meet temporary emergency needs;
- Repatriation of American citizens and dependents returned from foreign countries as a result of illness, destitution or war crises, who need emergency cash and services;
- Child care services to employed AFDC recipients, applicants, and recipients in approved education and training programs including JOBS participants, as well as transitional child care for former recipients who have left AFDC because of increased earnings;
- Child care services for families at risk of becoming AFDC recipients; and,
- State administrative expenses for AFDC and for Child Support Enforcement.

The Federal share of child support collections on behalf of AFDC recipients helps offset the costs of AFDC benefit payments. The first \$50 of current monthly collections are passed through to the AFDC family and do not offset benefits. In addition, part of these collections are retained by States as incentive payments under section 458 of the Social Security Act. Enforcement of child support orders helps reduce or avoid a family's dependence on welfare assistance.

Aid to Families with Dependent Children (AFDC)

Authorizing Legislation: Titles I, IV-A and -D, X, XI, XIV and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch.9).

(Dollars in thousands)

	1995 Actual	1996 Policy	Increase or Decrease	1997 Estimate	Increase or Decrease
	Appropriation				
AFDC benefit payments	\$12,249,781	\$11,275,626	-\$974,155	\$11,713,000	+\$437,374
Q.C. Collections	--	-40,700	-40,700	-52,000	-11,300
CSE Collections	-822,487	-853,000	-30,513	-907,000	-54,000
Subtotal	11,427,294	10,381,925	-1,045,368	10,754,000	+372,074
Territories - Adults	24,862	25,000	+138	25,000	--
Emergency Assistance	983,736	1,687,000	+703,264	1,867,000	+180,000
State/Local Welfare Admin.	1,779,902	1,678,900	-101,002	1,875,000	+196,100
AFDC child care	655,140	819,602	+164,462	879,405	+59,803
Trans. child care	199,688	249,398	+49,710	267,595	+18,197
At-risk child care	296,709	335,000	+38,291	300,000	-35,000
Repatriation	150	1,000	850	1,000	--
Total, budget authority	\$15,367,481	\$15,177,826	-\$189,655	\$15,969,000	+\$791,174

Purpose and Method of Operation

In his State of the Union message and in the FY 1997 budget the President continues to encourage enactment of a bipartisan welfare reform bill. If a bill is enacted, as proposed by the President in his FY 1997 Budget, the programs in this section of the budget would be affected and the current law numbers that appear would change.

Aid to Families with Dependent Children (AFDC)

The AFDC program provides transitional financial assistance to needy families with dependent children to cover basic needs such as food, shelter, and clothing. In order to be eligible, families must have a dependent child who is deprived of parental support or care because of a parent's death, incapacity, continued absence or the unemployment of the principal family earner in a two parent family.

The AFDC program is administered by State and local welfare agencies under approved State plans in accordance with Federal statutes and regulations. A State takes into consideration the needs as well as the income and resources of all individuals in the family in determining the amount of the assistance payment. Each State determines its own need and payment standards. The program is jointly funded by Federal, State, and, in some cases, local governments.

Payments to Territories - Adults (Aged, Blind and Disabled)

Maintenance assistance programs for the aged, blind and disabled were federalized under Title XVI of the Social Security Act as the Supplemental Security Income program on January 1, 1974. A small residual program, however, remains for the residents of Puerto Rico, Guam, and the Virgin Islands. These grants are subject to spending limitations under Section 1108 of the Social Security Act. The limitations, which were most recently amended by P.L. 100-485, are: \$82,000,000 for Puerto Rico, \$3,800,000 for Guam, and \$2,800,000 for the Virgin Islands. Section 601 of the Family Support Act (P.L. 100-485) provides a limitation of \$1,000,000 for American Samoa.

Emergency Assistance

The Emergency Assistance (EA) program is an optional program established to provide temporary assistance to needy families with children. This program is administered by State and local welfare agencies under State plans approved in accordance with Federal statutes and regulations. As of January 1996, 48 States, two Territories and the District of Columbia operate EA programs. Assistance may be in the form of cash payments, in-kind assistance, or vendor payments to prevent destitution of children and to meet emergency needs resulting from natural disasters, homelessness, family violence, or child abuse and neglect. Emergency Assistance benefits may include payments for rent, utilities, food, clothing, temporary shelter, alternative living arrangements, medical assistance, and family support services. Federal matching at fifty percent of the total EA costs is available.

Repatriation

This program provides assistance to U.S. citizens and their dependents returning from foreign countries who have been certified by the Department of State to be destitute or ill or requiring emergency repatriation due to threatened armed conflict, civil strife or natural disaster abroad. The funding level for the repatriate program, except for the mentally ill, is set by the authorizing statute, Section 1113 of the Social Security Act. Spending is entirely dependent upon external events, and is affected substantially by the extent of conflict and natural disasters abroad.

The repatriate program currently reimburses States directly for assistance provided by them to individual repatriates and for State administrative costs. During FY 1996, it is expected that the program will initiate a contract with a national, private organization for provision of some of the services currently provided by States. Individuals receiving assistance are expected to repay the cost of such assistance. These repatriate debts are collected by the Health Resources Services Administration, the HHS component charged with collecting debts owed by individuals.

AFDC Child Care

The Family Support Act of 1988 (P.L. 100-485) requires States to guarantee child care as a condition of participation in approved education and training activities (including JOBS) and for employed AFDC recipients. Federal financial participation is available for the actual cost of child care up to a statewide limit established by the State welfare agency in its State supportive services plan, but not for more than the applicable local market rate. The Federal matching rate for AFDC child care

payments is the same as AFDC benefit payments and is available as an open-ended entitlement.

Transitional Child Care

The Family Support Act of 1988 also requires States to guarantee up to 12 months of child care for employed former AFDC recipients who leave AFDC as a result of increased hours of work, earnings from employment, or expiration of the time-limited income disregards. Child care provisions for transitional assistance are essentially the same as the provisions for child care received during participation in the JOBS program, except that: (1) child care is limited to a period of 12 months after the last month for which the family was eligible for assistance and (2) families receiving child care assistance must contribute to the cost of the care in accordance with a sliding scale formula established by the State, based on the family's ability to pay. The Federal matching rate for transitional child care payments is the same as for AFDC benefit payments and is available as an open-ended entitlement.

At-Risk Child Care

The Omnibus Budget Reconciliation Act of 1990 amended the Social Security Act to provide States with the option to provide child care to low-income families who: (1) are not receiving AFDC; (2) need child care in order to work; and (3) would otherwise be at risk of becoming eligible for AFDC. Families contribute to the cost of providing the care according to the family's ability to pay. Section 403(n) of the Social Security Act authorizes \$300 million in Federal funds for allocation to States each fiscal year beginning with FY 1991. The statute allows States which underspend their allocation in any year to increase, subject to certain limits and for one year only, their ceiling allocation for the subsequent year. In FY 1996, 50 States and the District of Columbia have At-Risk Child Care programs.

State and Local Administration

The Federal government reimburses 50 percent of State and local administrative costs related to Assistance Payments programs. Activities include State and local administrative determination of eligibility for assistance, case management, and AFDC quality control reviews.

REVISIONS TO FY 1996 BUDGET ESTIMATES

Benefit Payments: AFDC payments decrease (-\$1,723,374,000), as do child support collections (+\$22,000,000) and collections of quality control sanctions (+\$30,421,000). The benefit payments activity consists of three components: AFDC payments and an offsetting amount from the Federal share of child support enforcement collections and the collection of quality control sanctions. The decrease in AFDC benefit payments is due primarily to an anticipated reduction in the AFDC caseload in FY 1996. Estimated child support collections and quality control sanctions are running below previous estimates, based on more recent trend information.

Payments to Territories - Adults (Aged, Blind, and Disabled): (+\$5,572,000) Payments to Territories are expected to increase slightly above previous estimates.

Emergency Assistance: (+\$713,000,000) Estimates of budget authority required for Emergency Assistance have been increased. States are continuing to expand their programs to include a wider range of services, such as child welfare and child protective services, as well as a broader range of recipients. As a result, States are expected to claim a higher level of reimbursement under the EA program in FY 1996 than previously estimated.

AFDC and Transitional Child Care: (+\$115,000,000) Estimated budget authority for AFDC and Transitional Child Care has been increased due to higher than anticipated utilization.

At Risk Child Care: (+\$35,000,000) The increase in available budget authority for the At-Risk Child Care program in FY 1996 reflects lower than anticipated State utilization of funds available for FY 1995. The statute allows States to increase a current year's funding ceiling, under certain conditions, when funds are not used in the previous year; this has the effect of increasing total budget authority available for FY 1996.

AFDC Administrative Costs: (-\$91,000,000) Budget authority for State and Local Administrative costs is expected to decrease due to lower AFDC caseloads.

Aid to Families with Dependent Children (AFDC)

Program Data:

(dollars in thousands)

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>1997 Request</u>
Service Grants			
Formula	\$12,249,781	\$11,275,626	\$11,713,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
Total Program	\$12,249,781	\$11,275,626	\$11,713,000
Number of Applicants	54	54	54
Number of Grants	54	54	54
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	54	54	54
\$	\$12,249,781	\$11,275,626	\$11,713,000
Contracts:			
#	--	--	--
\$	--	--	--

Payments to Territories - Adults (Aged, Blind, Disabled)

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants			
Formula	\$24,862,000	\$25,000,000	\$25,000,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
Total Program	\$24,862,000	\$25,000,000	\$25,000,000
Number of Applicants	3	3	3
Number of Grants	3	3	3
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	3	3	3
\$	\$24,862,000	\$25,000,000	\$25,000,000
Contracts:			
#	--	--	--
\$	--	--	--

Emergency Assistance

Program Data:

	<u>FY 1995</u> <u>Enacted</u>	<u>FY 1996</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>
Service Grants			
Formula	\$983,736,000	\$1,687,000,000	\$1,867,000,000
Discretionary			
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other (footnote)	--	--	--
Total Program	\$983,736,000	\$1,687,000,000	\$1,867,000,000
Number of Applicants	51	51	51
Number of Grants	51	51	51
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	51	51	51
\$	\$983,736,000	\$1,687,000,000	\$1,867,000,000
Contracts:			
#	--	--	--
\$	--	--	--

Repatriation

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other*/	\$150,000*	\$1,000,000	\$1,000,000
TOTAL PROGRAM	\$150,000	\$1,000,000	\$1,000,000
Number of Applicants	--	--	--
Number of Grants	--	--	--
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	--	--	--
\$	--	--	--
Contracts:		**	
#	--	1	1
\$	--	\$400,000	\$400,000

* The Repatriation Program reimburses States directly for assistance provided by States to individual repatriates and for State administrative costs. The Health Resources and Services Administration in PHS is responsible for collection of the repayments from repatriates.

** During FY 1996, ACF will initiate a contract for provision of some of the services to repatriates previously provided by the States.

AFDC Child Care

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants			
Formula	\$655,140,000	\$819,602,000	\$879,405,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
Total Program	\$655,140,000	\$819,602,000	\$879,405,000
Number of Applicants	51	51	51
Number of Grants	51	51	51
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	51	51	51
\$	\$655,140,000	\$819,602,000	\$879,405,000
Contracts:			
#	--	--	--
\$	--	--	--

Transitional Child Care

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants			
Formula	\$199,688,000	\$249,398,000	\$267,595,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
Total Program	\$199,688,000	\$249,398,000	\$267,595,000
Number of Applicants	54	54	54
Number of Grants	54	54	54
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	54	54	54
\$	\$199,688,000	\$249,398,000	\$267,595,000
Contracts:			
#	--	--	--
\$	--	--	--

At-Risk Child Care

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants			
Formula	\$296,709,000	\$335,000,000	\$300,000,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
Total Program	\$296,709,000	\$335,000,000	\$300,000,000
Number of Applicants	51	54	54
Number of Grants	51	54	54
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	51	54	54
\$	\$296,709,000	\$335,000,000	\$300,000,000
Contracts:			
#	--	--	--
\$	--	--	--

AFDC State and Local Administrative Costs

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants			
Formula	\$1,779,902,000	\$1,678,900,000	\$1,875,000,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
Total Program	\$1,779,902,000	\$1,678,900,000	\$1,875,000,000
Number of Applicants	54	54	54
Number of Grants	54	54	54
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	54	54	54
\$	\$1,779,902,000	\$1,678,900,000	\$1,875,000,000
Contracts:			
#	--	--	--
\$	--	--	--

Child Support Enforcement

Authorizing legislation: Title IV-D of the Social Security Act, as amended

(Dollars in Thousands)

	1995 Actual <u>Appropriation</u>	1996 Policy	Increase or <u>Decrease</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
CSE state admin. costs....	\$2,123,604	\$1,916,000	-\$207,604	\$2,132,000	+\$216,000
Total, budget authority	\$2,123,604	\$1,916,000	-\$207,604	\$2,132,000	+\$216,000

Purpose and Method of Operations

The Child Support Enforcement (CSE) program is a Federal/State effort to ensure that children are supported financially by both of their parents, to foster family responsibility, and to reduce the need for welfare and its cost to the taxpayer. All people with custody of children who need or are owed child support can get help from their State or local CSE agency. These agencies locate non-custodial parents, establish paternity when necessary, and establish and enforce orders for support.

The program strengthens families by helping children get the support they deserve from non-custodial parents. By securing support from non-custodial parents on a consistent and continuing basis, non-welfare families may avoid the need for public assistance, thus reducing welfare spending.

In non-AFDC cases, child support collections are forwarded to the custodial family. Applicants for AFDC assign their rights to support payments to the State as a condition of receipt of assistance. The AFDC family receives up to the first \$50 of each month's current child support collected, in addition to the AFDC payment. The remaining child support collections in AFDC cases are shared between the State and Federal government. A portion of the Federal share of child support collections is paid to the States as incentive payments based on their cost effectiveness in operating the program and collections achieved.

The Federal government provides funding in three ways. It provides a 66% match rate for general State administrative costs, a 90% match rate for paternity testing and full funding of incentive payments.

Rationale for Budget Request

In his State of the Union message and in the FY 1997 budget the President continues to encourage enactment of a bipartisan welfare reform bill. If a bill passes, as proposed by the President in his FY 1997 Budget, the programs in this section of the budget would be affected and the current law numbers that appear would change.

States have intensified their efforts to secure increased child support collections from non-custodial parents. Expanded outlays for the development, implementation, and operation of improved automatic data processing systems have promoted greater program efficiency. These outlays were supported by an enhanced (90%) match rate that expired on September 30, 1995. The expiration of this match rate accounts for a \$43,000,000 reduction in state administrative expenditures in FY 1997. In addition, estimated program costs reflect increases in State employee's salaries and other cost increases. The Federal share of these expenses is further increased by the payment of an incentive to States to encourage improvement in program effectiveness.

Since the creation of the child support enforcement program, total child support collections have increased annually. In recent years, States have increased collections by using approaches such as income withholding, offset of income tax refunds, support guidelines and closer links to credit bureaus. In FY 1997, \$12.5 billion in child support collections are projected to be distributed to families and shared by governments, an 8 percent gain in collections over FY 1996. In FY 1996, this represents a total return of almost \$4 for every dollar invested in the administration of the program. In the aggregate, the financial payments provided by non-custodial parents for child support have always exceeded the costs incurred to operate the program. Since the inception of the program in FY 1975, a total of \$83 billion has been collected.

The Office of Child Support Enforcement (OCSE) has been designated by OMB to be a Government Performance and Results Act (GPRA) pilot agency. Beginning in FY 1995, and continuing through FY 1996, OCSE is pilot testing the GPRA principles of results-oriented management and performance measurement in partnership with State and local child support enforcement programs across the nation.

The GPRA focus on partnership has permeated all of our activities. OCSE has developed with its state partners a five year national strategic plan which sets goals and objectives for the Child Support program. OCSE and its state partners are also close to consensus on a set of performance measures that will be used by our partners to measure performance outcomes. Federal

and State staff now undertake joint planning and share information in order to improve performance and get results.

As a GPRA pilot, OCSE must conduct performance planning for FY 1995 and FY 1996. Starting with a basic performance plan for FY 1995, OCSE's two measures of successful program results, tied to the objectives of the national strategic plan, are the total number of paternities established and the total child support dollars collected.

REVISIONS TO FY 1996 BUDGET ESTIMATES

Child Support Enforcement State administrative costs (-\$27,000,000): The Federal share of state administrative expenditures in FY 1996 is expected to increase at a somewhat slower rate than anticipated.

Child Support Enforcement

Program Data:

(dollars in thousands)

	<u>FY 1995</u> <u>Enacted</u>	<u>FY 1996</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>
Service Grants			
Formula*	\$2,123,604	\$1,916,000	\$2,132,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
Total Program	\$2,123,604	\$1,916,000	\$2,132,000
Number of Applicants	54	54	54
Number of Grants	54	54	54
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	54	54	54
\$	\$2,123,604	\$1,916,000	\$2,132,000
Contracts:			
#	--	--	--
\$	--	--	--

STATE TABLES

AFDC BENEFIT PAYMENTS

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
Alabama	\$61,152,328	\$56,712,753	\$58,912,603
Alaska	54,942,430	50,953,685	52,930,144
Arizona	172,054,344	159,563,436	165,752,795
Arkansas	39,371,143	36,512,852	37,929,161
California	3,103,831,008	2,878,497,165	2,990,152,148
Colorado	74,022,200	68,648,291	71,311,112
Connecticut	203,676,849	188,890,191	196,217,115
Delaware	19,428,334	18,017,864	18,716,765
Dist. of Col.	64,146,270	59,489,339	61,796,891
Florida	434,857,148	403,287,120	418,930,358
Georgia	261,986,372	242,966,523	252,391,032
Guam	3,219,425	2,985,699	3,101,512
Hawaii	84,751,107	78,598,294	81,647,069
Idaho	21,870,907	20,283,109	21,069,877
Illinois	451,753,501	418,956,821	435,207,876
Indiana	114,671,641	106,346,638	110,471,753
Iowa	94,739,234	87,861,296	91,269,377
Kansas	65,436,884	60,686,257	63,040,236
Kentucky	133,552,337	123,856,622	128,660,938
Louisiana	114,904,556	106,562,644	110,696,138
Maine	64,851,603	60,143,466	62,476,391
Maryland	155,370,297	144,090,628	149,679,807
Massachusetts	321,081,784	297,771,690	309,322,055
Michigan	583,436,643	541,079,949	562,068,079
Minnesota	198,071,488	183,691,772	190,817,053
Mississippi	62,561,254	58,019,393	60,269,926
Missouri	168,676,354	156,430,684	162,498,526
Montana	33,883,063	31,423,199	32,642,084
Nebraska	32,912,043	30,522,674	31,706,628
Nevada	26,692,690	24,754,838	25,715,062
New Hampshire	28,675,077	26,593,306	27,624,843
New Jersey	258,092,175	239,355,040	248,639,462
New Mexico	121,916,703	113,065,719	117,451,463
New York	1,496,030,755	1,387,420,989	1,441,238,122
North Carolina	217,874,809	202,057,399	209,895,071

AFDC BENEFIT PAYMENTS (continued)

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
North Dakota	15,714,235	14,573,403	15,138,696
Ohio	519,567,121	481,847,266	500,537,800
Oklahoma	104,836,868	97,225,856	100,997,182
Oregon	111,616,497	103,513,293	107,528,504
Pennsylvania	500,754,154	464,400,094	482,413,863
Puerto Rico	52,906,357	49,065,429	50,968,644
Rhode Island	73,747,639	68,393,662	71,046,606
South Carolina	77,909,436	72,253,319	75,055,977
South Dakota	15,845,879	14,695,490	15,265,518
Tennessee	139,692,782	129,551,279	134,576,487
Texas	344,949,322	319,906,478	332,315,437
Utah	52,627,738	48,807,037	50,700,229
Vermont	37,066,196	34,375,241	35,708,634
Virgin Islands	2,185,921	2,027,226	2,105,861
Virginia	127,182,824	117,949,527	122,524,710
Washington	311,678,879	289,051,423	300,263,535
West Virginia	81,550,284	75,629,846	78,563,477
Wisconsin	230,820,971	214,063,687	222,367,074
Wyoming	13,154,066	12,199,099	12,672,294
Financial Adjustments	91,479,075		
Total, Budget Authority	\$12,249,781,000	\$11,275,626,000	11,713,000,000

^{1/} Includes indefinite appropriation.

PAYMENTS TO TERRITORIES

State	1995 Enacted ¹⁷	1996 Estimate	1997 Estimate
Guam	\$713,108	\$717,068	\$717,068
Puerto Rico	23,616,681	23,747,824	23,747,824
Virgin Islands	532,153	535,108	535,108
Total, Budget Authority	\$24,861,942	\$25,000,000	\$25,000,000

¹⁷ Includes indefinite appropriation.

EMERGENCY ASSISTANCE

State	1995 Enacted ^{1/}	1996 Estimate ^{2/}	1997 Estimate ^{2/}
Alabama	\$9,119,529	\$7,611,410	\$8,615,371
Alaska	0	0	0
Arizona	10,315,887	20,392,725	24,742,021
Arkansas	2,481,440	1,528,722	1,834,411
California	248,172,449	285,347,677	328,904,392
Colorado	29,944,674	44,251,568	57,795,887
Connecticut	(11,500,000)	53,865,365	60,970,320
Delaware	7,526,727	12,705,200	14,447,315
Dist. of Col.	4,473,644	3,464,948	3,921,982
Florida	23,772,558	25,742,375	29,137,848
Georgia	8,650,329	10,775,415	12,349,141
Guam	0	0	0
Hawaii	431,581	719,571	814,484
Idaho	4,893,767	4,730,784	5,622,524
Illinois	44,553,118	66,512,016	75,285,091
Indiana	32,307,719	19,965,315	23,261,502
Iowa	5,787,731	14,554,187	15,754,200
Kansas	14,716,717	14,537,794	17,114,104
Kentucky	811,421	1,157,520	1,310,199
Louisiana	12,489,271	10,132,544	11,927,650
Maine	2,069,152	2,180,376	2,467,973
Maryland	7,533,409	10,384,891	11,871,982
Massachusetts	27,930,194	34,368,445	38,901,715
Michigan	9,967,846	16,042,511	23,062,686
Minnesota	11,751,959	16,765,595	19,452,183
Mississippi	0	0	0
Missouri	16,626,665	23,930,274	28,437,352
Montana	1,234,131	1,773,459	2,108,115
Nebraska	5,162,654	6,616,072	7,952,650
Nevada	3,782,338	13,466,341	15,242,580
New Hampshire	1,151,113	2,579,097	3,250,646
New Jersey	19,959,121	46,115,193	51,578,240
New Mexico	517,122	844,281	984,803
New York	196,591,198	461,810,023	477,213,368
North Carolina	17,101,698	102,016,317	115,472,484

EMERGENCY ASSISTANCE (continued)

State	1995 Enacted ^{1/}	1996 Estimate ^{2/}	1997 Estimate ^{2/}
North Dakota	5,094,186	7,213,275	8,317,147
Ohio	15,516,221	22,992,899	26,123,131
Oklahoma	522,846	1,171	1,325
Oregon	7,928,891	15,644,376	17,321,535
Pennsylvania	114,197,041	207,392,780	211,023,579
Puerto Rico	85,719	117,099	132,544
Rhode Island	4,349,042	9,555,247	11,356,385
South Carolina	4,176,077	5,658,205	6,724,629
South Dakota	1,367,790	1,218,997	1,420,874
Tennessee	23,328,056	22,610,572	26,050,232
Texas	10,957,946	15,889,697	18,849,107
Utah	6,728,079	7,650,638	8,227,680
Vermont	1,395,340	2,604,273	3,078,338
Virgin Islands	180	585	663
Virginia	20,609	53,865	62,958
Washington	10,963,559	23,894,559	27,571,176
West Virginia	2,372,769	2,716,102	3,074,362
Wisconsin	1,248,406	2,210,236	2,664,801
Wyoming	3,155,633	2,687,413	3,194,315
Total, Budget Authority	\$983,735,552	\$1,687,000,000	\$1,867,000,000

^{1/} Includes indefinite appropriation.

^{2/} Amounts reflect State estimates of total expenditures.

AFDC STATE AND LOCAL ADMINISTRATION

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
Alabama	\$10,978,186	\$10,355,219	\$11,564,736
Alaska	4,924,169	4,644,743	5,187,261
Arizona	23,852,669	22,499,129	25,127,087
Arkansas	6,641,311	6,264,444	6,996,148
California	302,058,589	284,918,017	318,197,200
Colorado	11,930,980	11,253,946	12,568,437
Connecticut	17,232,069	16,254,220	18,152,756
Delaware	3,843,454	3,625,354	4,048,805
Dist. of Col.	16,991,881	16,027,662	17,899,736
Florida	95,967,863	90,522,084	101,095,305
Georgia	33,272,993	31,384,888	35,050,727
Guam	372,176	351,057	392,061
Hawaii	6,110,610	5,763,858	6,437,092
Idaho	4,971,877	4,689,744	5,237,519
Illinois	67,971,696	64,114,584	71,603,338
Indiana	13,263,634	12,510,978	13,972,294
Iowa	17,711,753	16,706,684	18,658,069
Kansas	2,148,734	2,026,802	2,263,538
Kentucky	16,687,648	15,740,693	17,579,248
Louisiana	6,158,767	5,809,282	6,487,822
Maine	3,351,043	3,160,885	3,530,085
Maryland	58,693,587	55,362,969	61,829,512
Massachusetts	46,501,590	43,862,817	48,986,111
Michigan	82,192,823	77,528,721	86,584,282
Minnesota	37,665,345	35,527,993	39,677,757
Mississippi	8,111,813	7,651,501	8,545,217
Missouri	19,067,424	17,985,427	20,086,173
Montana	6,194,773	5,843,245	6,525,752
Nebraska	11,698,253	11,034,426	12,323,276
Nevada	15,559,011	14,676,102	16,390,310
New Hampshire	6,427,829	6,063,076	6,771,259
New Jersey	80,967,734	76,373,150	85,293,738
New Mexico	13,095,120	12,352,026	13,794,776
New York	251,116,691	236,866,859	264,533,540
North Carolina	47,507,212	44,811,374	50,045,462

AFDC STATE AND LOCAL ADMINISTRATION (continued)

State	1995 Enacted ¹¹	1996 Estimate	1997 Estimate
North Dakota	2,732,863	2,577,784	2,878,876
Ohio	35,569,759	33,551,322	37,470,206
Oklahoma	19,351,895	18,253,755	20,385,842
Oregon	33,028,281	31,154,063	34,792,941
Pennsylvania	83,737,015	78,985,286	88,210,978
Puerto Rico	6,015,648	5,674,285	6,337,057
Rhode Island	7,994,652	7,540,989	8,421,797
South Carolina	10,194,288	9,615,804	10,738,956
South Dakota	2,332,691	2,200,320	2,457,323
Tennessee	13,767,884	12,986,614	14,503,485
Texas	94,556,246	89,190,571	99,608,268
Utah	9,597,644	9,053,017	10,110,434
Vermont	3,749,162	3,536,413	3,949,475
Virgin Islands	290,496	274,012	306,017
Virginia	22,487,612	21,211,533	23,689,097
Washington	40,698,697	38,389,214	42,873,177
West Virginia	4,099,537	3,866,905	4,318,570
Wisconsin	36,142,219	34,091,298	38,073,253
Wyoming	2,314,176	2,182,856	2,437,819
Total, Budget Authority	\$1,779,902,072	\$1,678,900,000	\$1,875,000,000

¹¹ Includes indefinite appropriation.

AFDC/JOBS CHILD CARE

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
Alabama	\$7,246,887	\$9,066,097	\$9,727,613
Alaska	1,948,072	2,437,103	2,614,928
Arizona	9,721,028	12,161,330	13,048,692
Arkansas	1,782,132	2,229,507	2,392,185
California	38,794,179	48,532,814	52,074,057
Colorado	4,472,180	5,594,846	6,003,079
Connecticut	10,472,372	13,101,287	14,057,234
Delaware	3,293,222	4,119,931	4,420,545
Dist. of Col.	3,705,330	4,635,491	4,973,724
Florida	15,213,624	19,032,751	20,421,493
Georgia	29,480,757	36,881,411	39,572,496
Guam	0	0	0
Hawaii	3,362,778	4,206,947	4,513,911
Idaho	1,009,319	1,262,692	1,354,825
Illinois	34,869,396	43,622,778	46,805,753
Indiana	12,894,754	16,131,768	17,308,837
Iowa	3,892,187	4,869,256	5,224,546
Kansas	3,578,610	4,476,961	4,803,627
Kentucky	9,651,501	12,074,350	12,955,366
Louisiana	8,587,960	10,743,825	11,527,758
Maine	936,344	1,171,398	1,256,870
Maryland	15,252,487	19,081,370	20,473,659
Massachusetts	28,492,388	35,644,928	38,245,792
Michigan	15,810,904	19,779,968	21,223,231
Minnesota	12,355,715	15,457,412	16,585,276
Mississippi	4,036,718	5,050,069	5,418,552
Missouri	12,951,277	16,202,480	17,384,709
Montana	1,559,164	1,950,566	2,092,891
Nebraska	6,142,802	7,684,850	8,245,582
Nevada	575,387	719,828	772,351
New Hampshire	2,570,180	3,215,381	3,449,994
New Jersey	12,471,045	15,601,693	16,740,085
New Mexico	1,752,017	2,191,832	2,351,761
New York	71,295,885	89,193,531	95,701,618
North Carolina	48,087,714	60,159,335	64,548,915

AFDC/JOBS CHILD CARE (continued)

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
North Dakota	1,021,275	1,277,649	1,370,874
Ohio	37,055,777	46,358,013	49,740,567
Oklahoma	14,954,063	18,708,032	20,073,080
Oregon	9,334,414	11,677,663	12,529,734
Pennsylvania	33,354,576	41,727,688	44,772,386
Puerto Rico	0	0	0
Rhode Island	4,707,139	5,888,788	6,318,469
South Carolina	3,673,301	4,595,422	4,930,731
South Dakota	647,278	809,766	868,851
Tennessee	24,974,768	31,244,268	33,524,034
Texas	23,467,754	29,358,943	31,501,145
Utah	6,271,785	7,846,212	8,418,718
Vermont	1,891,519	2,366,353	2,539,016
Virgin Islands	0	0	0
Virginia	8,132,361	10,173,855	10,916,200
Washington	27,222,317	34,056,027	36,540,956
West Virginia	5,058,098	6,327,849	6,789,566
Wisconsin	13,557,600	16,961,010	18,198,585
Wyoming	1,549,660	1,938,676	2,080,133
Total, Budget Authority	\$655,140,000	\$819,602,000	\$879,405,000

^{1/} Includes indefinite appropriation.

TRANSITIONAL CHILD CARE

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
Alabama	\$4,202,955	\$5,249,232	\$5,632,235
Alaska	674,684	842,639	904,121
Arizona	4,644,395	5,800,563	6,223,794
Arkansas	472,102	589,626	632,647
California	4,248,881	5,306,593	5,693,779
Colorado	1,308,760	1,634,561	1,753,825
Connecticut	4,137,187	5,167,091	5,544,101
Delaware	922,928	1,152,680	1,236,784
Dist. of Col.	190,269	237,634	254,973
Florida	12,278,597	15,335,211	16,454,125
Georgia	5,347,969	6,679,284	7,166,629
Guam	209	261	280
Hawaii	146,044	182,400	195,709
Idaho	222,220	277,539	297,789
Illinois	6,807,473	8,502,114	9,122,460
Indiana	7,252,731	9,058,214	9,719,135
Iowa	1,269,194	1,585,145	1,700,803
Kansas	2,318,105	2,895,170	3,106,412
Kentucky	2,355,223	2,941,528	3,156,153
Louisiana	2,590,478	3,235,347	3,471,410
Maine	680,172	849,493	911,475
Maryland	1,813,982	2,265,552	2,430,855
Massachusetts	8,603,709	10,745,502	11,529,534
Michigan	4,505,771	5,627,430	6,038,028
Minnesota	4,852,451	6,060,412	6,502,602
Mississippi	850,063	1,061,676	1,139,140
Missouri	4,991,220	6,233,726	6,688,562
Montana	757,784	946,425	1,015,480
Nebraska	1,440,799	1,799,469	1,930,765
Nevada	598,120	747,015	801,520
New Hampshire	615,700	768,971	825,078
New Jersey	4,743,064	5,923,794	6,356,016
New Mexico	1,338,555	1,671,773	1,793,752
New York	7,860,410	9,817,167	10,533,464
North Carolina	11,575,916	14,457,605	15,512,485

TRANSITIONAL CHILD CARE (continued)

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
North Dakota	367,790	459,347	492,863
Ohio	13,511,087	16,874,515	18,105,742
Oklahoma	5,292,388	6,609,866	7,092,146
Oregon	5,937,498	7,415,569	7,956,636
Pennsylvania	7,740,387	9,667,266	10,372,625
Puerto Rico	0	0	0
Rhode Island	671,738	838,959	900,173
South Carolina	1,493,454	1,865,232	2,001,326
South Dakota	367,409	458,871	492,352
Tennessee	8,822,024	11,018,164	11,822,090
Texas	17,017,394	21,253,676	22,804,423
Utah	2,872,556	3,587,645	3,849,413
Vermont	589,181	735,851	789,541
Virgin Islands	652	814	873
Virginia	4,944,903	6,175,879	6,626,494
Washington	7,054,139	8,810,185	9,453,009
West Virginia	1,608,771	2,009,256	2,155,859
Wisconsin	4,365,875	5,452,709	5,850,559
Wyoming	412,634	515,354	552,956
Total, Budget Authority	\$199,688,000	\$249,398,000	\$267,595,000

^{1/} Includes indefinite appropriation.

AT-RISK CHILD CARE

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
Alabama	\$4,978,261	\$4,704,169	\$4,544,936
Alaska	858,575	904,954	849,003
Arizona	4,769,413	5,004,165	5,004,165
Arkansas	2,776,721	2,681,610	2,681,610
California	55,766,308	43,730,958	39,041,444
Colorado	3,990,465	4,201,350	4,201,149
Connecticut	3,448,230	3,473,556	3,473,556
Delaware	777,801	763,129	763,129
Dist. of Col.	526,757	542,896	542,896
Florida	14,320,946	14,309,700	14,309,700
Georgia	1,341,528	15,937,743	8,158,330
Guam	0	391,203	194,834
Hawaii	1,333,575	1,340,079	1,340,079
Idaho	1,396,193	1,401,965	1,401,965
Illinois	14,876,467	13,362,731	13,362,731
Indiana	7,432,674	7,473,877	6,223,783
Iowa	3,113,742	3,033,988	3,033,988
Kansas	2,972,308	2,974,384	2,947,617
Kentucky	4,142,395	4,031,165	4,031,165
Louisiana	5,345,915	8,382,382	5,221,316
Maine	1,317,800	1,292,002	1,292,002
Maryland	5,561,797	5,595,208	5,595,208
Massachusetts	6,225,960	6,287,736	6,287,736
Michigan	8,241,800	10,812,799	10,812,799
Minnesota	5,358,590	5,304,687	5,304,687
Mississippi	1,308,786	5,172,399	3,159,142
Missouri	5,893,869	5,871,547	5,871,547
Montana	857,307	1,211,334	988,841
Nebraska	1,894,162	1,869,844	1,869,844
Nevada	1,712,802	1,911,046	1,666,945
New Hampshire	1,259,145	1,271,238	1,271,238
New Jersey	8,363,489	8,441,069	8,441,069
New Mexico	1,374,564	3,073,501	2,138,455
New York	19,697,250	19,785,244	19,785,244
North Carolina	7,411,014	7,572,583	7,572,583

AT-RISK CHILD CARE (continued)

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
North Dakota	594,698	718,205	718,205
Ohio	12,598,496	12,149,459	12,149,459
Oklahoma	2,615,580	3,729,025	3,729,025
Oregon	3,351,616	3,310,658	3,310,658
Pennsylvania	12,484,814	12,429,158	12,429,158
Puerto Rico	0	10,301,687	5,130,624
Rhode Island	820,600	1,055,600	1,050,969
South Carolina	5,728,177	4,067,569	4,067,569
South Dakota	604,939	1,127,683	876,640
Tennessee	5,441,178	8,582,394	5,502,314
Texas	18,622,941	28,601,838	23,020,678
Utah	1,729,719	2,796,568	2,796,568
Vermont	627,591	623,031	623,031
Virgin Islands	0	355,640	177,122
Virginia	6,610,986	6,968,125	6,968,125
Washington	6,117,344	6,078,668	6,078,668
West Virginia	1,760,839	1,723,553	1,723,553
Wisconsin	5,781,588	5,699,055	5,699,055
Wyoming	571,520	563,843	563,843
Total, Budget Authority	\$296,709,235	\$335,000,000	\$300,000,000

^{1/} Includes indefinite appropriation.

CHILD SUPPORT ENFORCEMENT
NET FEDERAL SHARE OF AFDC COLLECTIONS

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
Alabama	\$8,952,990	\$9,285,133	\$9,872,937
Alaska	3,600,122	3,733,681	3,970,045
Arizona	7,416,840	7,691,994	8,178,943
Arkansas	6,569,382	6,813,096	7,244,405
California	116,265,858	120,579,140	128,212,525
Colorado	9,620,653	9,977,565	10,609,204
Connecticut	13,455,246	13,954,415	14,837,813
Delaware	2,164,910	2,245,225	2,387,361
Dist. of Col.	1,311,143	1,359,784	1,445,866
Florida	26,584,546	27,570,792	29,316,188
Georgia	8,253,785	8,559,987	9,101,886
Guam	639,274	662,990	704,961
Hawaii	3,008,163	3,119,761	3,317,260
Idaho	4,431,809	4,596,222	4,887,191
Illinois	14,967,213	15,522,474	16,505,139
Indiana	17,149,997	17,786,236	18,912,211
Iowa	15,666,419	16,247,619	17,276,190
Kansas	9,193,770	9,534,844	10,138,457
Kentucky	16,477,077	17,088,352	18,170,146
Louisiana	11,443,846	11,868,395	12,619,735
Maine	6,023,686	6,247,155	6,642,637
Maryland	12,150,412	12,601,174	13,398,903
Massachusetts	16,650,565	17,268,275	18,361,460
Michigan	56,613,602	58,713,879	62,430,819
Minnesota	20,726,988	21,495,927	22,856,748
Mississippi	10,544,867	10,936,065	11,628,384
Missouri	20,245,429	20,996,504	22,325,708
Montana	2,771,589	2,874,411	3,056,378
Nebraska	3,610,636	3,744,585	3,981,640
Nevada	1,323,760	1,372,869	1,459,780
New Hampshire	2,593,896	2,690,126	2,860,427
New Jersey	25,973,661	26,937,244	28,642,532
New Mexico	7,278,051	7,548,055	8,025,892
New York	53,844,115	55,841,649	59,376,759
North Carolina	27,403,616	28,420,248	30,219,420

CHILD SUPPORT ENFORCEMENT
NET FEDERAL SHARE OF AFDC COLLECTIONS (continued)

State	1995 Enacted "	1996 Estimate	1997 Estimate
North Dakota	2,720,069	2,820,979	2,999,564
Ohio	42,722,009	44,306,930	47,111,824
Oklahoma	10,178,967	10,556,591	11,224,886
Oregon	10,338,785	10,722,338	11,401,126
Pennsylvania	37,216,682	38,597,364	41,040,808
Puerto Rico	567,776	588,840	626,117
Rhode Island	5,186,741	5,379,161	5,719,694
South Carolina	11,080,049	11,491,101	12,218,557
South Dakota	2,352,066	2,439,324	2,593,748
Tennessee	14,219,641	14,747,168	15,680,752
Texas	30,796,605	31,939,112	33,961,048
Utah	10,898,150	11,302,454	12,017,967
Vermont	2,643,314	2,741,377	2,914,922
Virgin Islands	151,407	157,024	166,965
Virginia	9,703,717	10,063,710	10,700,803
Washington	35,412,416	36,726,162	39,051,147
West Virginia	5,993,194	6,215,532	6,609,012
Wisconsin	23,645,778	24,523,000	26,075,453
Wyoming	1,731,718	1,795,962	1,909,657
Total	\$822,487,000	\$853,000,000	\$907,000,000

CHILD SUPPORT ENFORCEMENT
FEDERAL SHARE OF STATE AND LOCAL ADMINISTRATIVE COSTS

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
Alabama	\$51,325,854	\$46,321,859	\$51,543,947
Alaska	11,116,084	10,032,326	11,163,319
Arizona	44,448,062	40,114,615	44,636,931
Arkansas	21,413,641	19,325,926	21,504,632
California	259,752,576	234,428,096	260,856,311
Colorado	24,285,275	21,917,591	24,388,468
Connecticut	27,257,578	24,600,111	27,373,401
Delaware	9,281,901	8,376,966	9,321,342
Dist. of Col.	6,283,171	5,670,596	6,309,870
Florida	62,540,415	56,443,060	62,806,161
Georgia	45,867,456	41,395,625	46,062,355
Guam	3,952,183	3,566,866	3,968,976
Hawaii	18,173,932	16,402,071	18,251,156
Idaho	13,108,713	11,830,684	13,164,415
Illinois	71,867,452	64,860,761	72,172,830
Indiana	21,712,877	19,595,988	21,805,139
Iowa	18,760,747	16,931,675	18,840,465
Kansas	27,683,402	24,984,419	27,801,034
Kentucky	27,432,992	24,758,423	27,549,560
Louisiana	28,166,287	25,420,225	28,285,971
Maine	8,908,058	8,039,570	8,945,910
Maryland	35,949,530	32,444,644	36,102,287
Massachusetts	57,745,787	52,115,883	57,991,160
Michigan	93,224,632	84,135,731	93,620,761
Minnesota	52,851,512	47,698,773	53,076,088
Mississippi	23,906,185	21,575,460	24,007,767
Missouri	46,908,228	42,334,928	47,107,550
Montana	6,318,336	5,702,332	6,345,184
Nebraska	19,400,113	17,508,706	19,482,546
Nevada	20,661,340	18,646,970	20,749,134
New Hampshire	12,158,123	10,972,771	12,209,785
New Jersey	74,149,538	66,920,356	74,464,613
New Mexico	13,603,649	12,277,366	13,661,453
New York	119,643,514	107,978,914	120,151,902
North Carolina	63,237,683	57,072,349	63,506,393

CHILD SUPPORT ENFORCEMENT
FEDERAL SHARE OF STATE AND LOCAL ADMINISTRATIVE COSTS
(continued)

State	1995 Enacted ^{1/}	1996 Estimate	1997 Estimate
North Dakota	4,170,749	3,764,123	4,188,471
Ohio	111,037,698	100,212,119	111,509,519
Oklahoma	15,205,471	13,723,019	15,270,082
Oregon	15,585,162	14,065,692	15,651,386
Pennsylvania	83,268,847	75,150,582	83,622,673
Puerto Rico	17,477,717	15,773,733	17,551,983
Rhode Island	5,013,418	4,524,637	5,034,721
South Carolina	37,150,140	33,528,201	37,307,998
South Dakota	3,373,659	3,044,745	3,387,994
Tennessee	32,504,938	29,335,881	32,643,058
Texas	113,986,324	102,873,270	114,470,674
Utah	23,131,226	20,876,056	23,229,515
Vermont	5,600,820	5,054,770	5,624,619
Virgin Islands	5,040,060	4,548,681	5,061,476
Virginia	47,461,199	42,833,987	47,662,871
Washington	74,464,403	67,204,524	74,780,817
West Virginia	20,211,012	18,240,547	20,296,893
Wisconsin	57,230,796	51,651,101	57,473,981
Wyoming	7,968,591	7,191,696	8,002,451
Financial Adjustments	625,033		
Total, Budget Authority	\$2,123,604,089	\$1,916,000,000	\$2,132,000,000

^{1/} Includes indefinite appropriation.

In his State of the Union message and in the FY 1997 budget the President continues to encourage enactment of a bipartisan welfare reform bill. If a bill is enacted, as proposed by the President in his FY 1997 Budget, the programs in this section of the budget would be affected and the current law numbers that appear would change.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Payments to States for the Job Opportunities and Basic
Skills Training Program

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation language and explanation of language changes .	C-3
Amount available for obligation	C-4
Summary of changes	C-5
Budget authority by activity	C-6
Budget authority by object	C-7
Authorizing legislation	C-8
Appropriation history table	C-9
Justification:	
A. General Statement	C-10
B. Payments to States for the Job Opportunities and Basic Skills Training Program	C-11
C. State Tables	C-14

PAYMENTS TO STATES FOR THE
JOB OPPORTUNITIES AND BASIC SKILLS TRAINING PROGRAM

For carrying out the Job Opportunities and Basic Skills Training Program (JOBS), as authorized by part F of title IV of the Social Security Act, \$1,000,000,000.

Note.-A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families

Payments to States for the Job Opportunities and Basic
Skills Training Program

Amounts Available for Obligation

	1995 Appropriation	1996 Policy ¹¹	1997 Estimate
Annual (definite)....	\$1,300,000,000	\$1,000,000,000	\$1,000,000,000
Unobligated balance lapsing	-288,243,000	-10,000,000	0
Total obligations .	\$1,011,757,000	\$990,000,000	\$1,000,000,000

550

¹¹ Based on levels of the ninth CR, including an incremental policy adjustment.

Payments to States for the Job Opportunities and Basic
Skills Training Program

SUMMARY OF CHANGES

1996 Policy/appropriation	\$1,000,000,000
Total estimated budget authority	\$1,000,000,000
(Obligations - current estimate) .	(\$990,000,000)
1997 Estimate	\$1,000,000,000
(Obligations)	(\$1,000,000,000)
Net change	0
(Obligations - current estimate) .	(+\$10,000,000)

Payments to States for the Job Opportunities and Basic
Skills Training Program

Budget Authority by Activity

	1995 <u>Actual</u>	1996 <u>Policy</u>	1997 <u>Estimate</u>
1. JOBS Program	<u>\$1,300,000,000</u>	<u>\$1,000,000,000</u>	<u>\$1,000,000,000</u>
Total, budget authority	\$1,300,000,000	\$1,000,000,000	\$1,000,000,000

Payments to States for the Job Opportunities and Basic
Skills Training Program

Budget Authority by Object

	1996 <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Grants, subsidies and contributions	<u>\$1,000,000,000</u>	<u>\$1,000,000,000</u>	<u>0</u>
Total, budget authority	\$1,000,000,000	\$1,000,000,000	0

Payments to States for the Job Opportunities and Basic Skills Training Program

Authorizing Legislation

	1996 Amount Authorized	1996 Policy	1997 Amount Authorized	1997 Budget Request
Job Opportunities and Basic Skills Training Program, Title IV-A, section 403 and Title IV-F of the Social Security Act, as amended.....	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000
Total Appropriation	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000

Payments to States for the Job Opportunities and Basic
Skills Training Program
Appropriation History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation/ Policy
1990 ^{1/} Indefinite Sequester	\$349,975,000	\$349,975,000	\$349,975,000	\$349,975,000 184,168,000 -3,608,000
1991	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000
1992	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000
1993	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000
1994	\$1,100,000,000	\$1,100,000,000	\$1,100,000,000	\$1,100,000,000
1995	\$1,300,000,000	\$1,300,000,000	\$1,300,000,000	\$1,300,000,000
1996	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000 ^{2/}	\$1,000,000,000
1997	\$1,000,000,000			

^{1/} This account was authorized by the Family Support Act (P.L. 100-485) in October, 1988. States were eligible to begin JOBS programs in the fourth quarter of FY 1989. Funding for that quarter was made available under the Family Support Payments to States account. FY 1990 was the first year that funding was requested for this account and provided as a separate appropriation.

^{2/} Senate Committee Mark

Justification
Payments to States for the Job Opportunities and Basic
Skills Training Program

	1996 Policy	1997 Estimate	Increase or Decrease
<u>Grants to States</u>			
Total, budget authority....	\$1,000,000,000	\$1,000,000,000	0

General Statement

This account provides payments to States, Territories, Indian Tribes, and Alaska Native Organizations to fund the Job Opportunities and Basic Skills Training (JOBS) program authorized under sections 201 and 301 of the Family Support Act of 1988 (P.L. 100-485). This program makes it possible for AFDC recipients to obtain jobs and leave the AFDC rolls. All States are currently operating a JOBS program.

The JOBS program provides an array of education, training and employment services to recipients of AFDC, and at State option, applicants. The State plans must be updated biennially outlining the method of operation for the program.

State JOBS programs must include educational activities such as high school or equivalent education, basic and remedial education, and education for those with limited English proficiency. All JOBS programs must also provide job skills training, job readiness, and job development and placement services. Finally, each State's program must offer at least two (and Tribal programs at least one) of the following programs: group and individual job search, on-the-job training, work supplementation, and community work experience or other work experience approved by the Secretary.

Section 301 of the Family Support Act provides for transportation and other work-related expenses or supportive services while an AFDC applicant/recipient participates in JOBS education, training or employment activities. For the Territories, child care to permit participation in JOBS activities or employment is paid for under this account.

The President's appropriation request of \$1,000,000,000 for this account represents current law authorization. No proposed law amounts are included.

Payments to States for the Job Opportunities and Basic Skills Training Program

Authorizing Legislation - Title IV-F of the Social Security Act, as amended

	1996 <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Total, budget authority	\$1,000,000,000	\$1,000,000,000	0

1997 Authorization \$1,000,000,000

Purpose and Method of Operations:

The Job Opportunities and Basic Skills Training Program (JOBS) assures that needy families with children obtain the education, training and employment needed to avoid long-term welfare dependency. State JOBS programs provide educational activities, job skills training, job readiness, and job development and placement services. Additionally, each State's program offers at least two, and Tribal programs at least one, of the following optional program components: group and individual job search; on-the-job training; work supplementation; community work experience or other work experience approved by the Secretary.

Fifty States, D.C., and Territories met the statutory deadline of October 1, 1992, for having a statewide program; 4 States were granted waivers of the requirement because they demonstrated it was infeasible to do so as provided in the law. In addition to the States and Territories, 77 Indian Tribes and Alaska Native Organizations operate JOBS programs.

Each State and Tribe submits a plan, updated biennially, outlining its implementation and operation of JOBS. A State's JOBS "limit of entitlement," i.e., its share of the funds appropriated for JOBS, is based on a combination of its FY 1987 allocation for the Work Incentive Program (WIN) and its share of AFDC adult recipients. Funds provided to a State for JOBS are matched at 90 percent up to the total that the State received in FY 1987 for WIN. Additional State expenditures for program costs are matched at the FMAP (Federal Medical Assistance Percentage) with a floor of 60 percent. Administrative costs and expenditures for transportation and other work-related supportive services are matched at 50 percent. Federal matching in any year is available up to a State's limit of entitlement.

A Tribe's JOBS program receives a portion of the State's JOBS funds based on the number of adult members of the Indian Tribe or Alaska Native organization receiving AFDC who live within the designated service area of the State. Tribal JOBS programs are not required to match Federal funds.

Rationale for the Budget Request

In his State of the Union message and in the FY 1997 budget the President continues to encourage enactment of a bipartisan welfare reform bill. If a bill is enacted, as proposed by the President in his FY 1997 Budget, the programs in this section of the budget would be affected and the current law numbers that appear would change.

The \$1,000,000,000 request is the amount to which States are entitled by law in FY 1997.

Payments to States for the Job Opportunities and Basic Skills
Training Program

Program Data:

	<u>FY 1995</u> <u>Enacted</u>	<u>FY 1996</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>
Service Grants			
Formula	1,300,000,000	1,000,000,000	1,000,000,000
Discretionary	--	--	--
Obligations	[1,011,757,000]	[990,000,000]	[1,000,000,000]
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
 Total Program	 \$1,300,000,000	 \$1,000,000,000	 \$1,000,000,000
Number of Applicants	131	131	131
Number of Grants	131	131	131
New Starts:			
#	131*	--	131
\$	1,011,757,000	--	\$1,000,000,000
Continuations:			
#	--	131	--
\$	--	\$990,000,000	--
Contracts:			
#	--	--	--
\$	--	--	--

* States were required to submit a biennial update to the State plan for the FY 1995 JOBS program. Because of this two-year cycle, one year funds are counted as new starts, and the following year as continuations.

STATE TABLES

JOB OPPORTUNITIES AND BASIC SKILLS (JOBS) PROGRAM
FEDERAL OBLIGATIONS TO STATES

State	1995 Enacted	1996 Estimate	1997 Estimate
Alabama	\$10,064,366	\$7,647,968	\$7,647,968
Alaska	3,982,399	3,095,641	3,095,641
American Samoa	0	89,692	89,692
Arizona	15,284,188	13,017,811	13,017,811
Arkansas	5,756,799	4,373,481	4,373,481
California	138,368,024	180,033,278	180,033,278
Colorado	10,759,000	9,457,013	9,457,013
Connecticut	10,115,797	12,551,052	12,551,052
Delaware	2,693,294	2,083,293	2,083,293
Dist. of Col.	5,501,589	5,554,930	5,554,930
Florida	18,948,513	40,318,468	40,318,468
Georgia	32,150,530	24,507,872	24,507,872
Guam	321,003	599,912	599,912
Hawaii	6,026,288	4,902,494	4,902,494
Idaho	2,985,876	2,546,774	2,546,774
Illinois	44,036,620	49,618,130	49,618,130
Indiana	15,092,831	14,447,995	14,447,995
Iowa	11,174,169	8,577,875	8,577,875
Kansas	8,008,804	6,066,039	6,066,039
Kentucky	16,379,838	14,116,956	14,116,956
Louisiana	18,270,320	14,648,569	14,648,569
Maine	4,001,508	5,200,530	5,200,530
Maryland	13,697,793	16,261,419	16,261,419
Massachusetts	21,690,792	24,278,187	24,278,187
Michigan	66,600,968	50,259,085	50,259,085
Minnesota	15,228,169	13,837,599	13,837,599
Mississippi	11,861,465	8,758,011	8,758,011
Missouri	14,279,679	17,633,739	17,633,739
Montana	3,058,325	2,884,736	2,884,736
Nebraska	3,788,929	3,039,571	3,039,571
Nevada	1,616,538	2,660,486	2,660,486

JOB OPPORTUNITIES AND BASIC SKILLS (JOBS) PROGRAM
FEDERAL OBLIGATIONS TO STATES (continued)

State	1995 Enacted	1996 Estimate	1997 Estimate
New Hampshire	2,920,000	2,311,260	2,311,260
New Jersey	30,383,129	25,266,086	25,266,086
New Mexico	2,109,568	7,568,468	7,568,468
New York	119,754,715	97,131,132	97,131,132
North Carolina	27,822,455	22,375,616	22,375,616
North Dakota	1,880,489	1,413,736	1,413,736
Ohio	62,781,496	48,495,809	48,495,809
Oklahoma	8,503,243	8,467,319	8,467,319
Oregon	13,157,602	10,414,175	10,414,175
Pennsylvania	56,538,467	44,412,926	44,412,926
Puerto Rico	13,004,148	11,632,480	11,632,480
Rhode Island	5,300,000	4,807,491	4,807,491
South Carolina	5,814,720	7,731,220	7,731,220
South Dakota	1,893,619	1,521,698	1,521,698
Tennessee	10,731,901	18,896,849	18,896,849
Texas	41,654,723	47,729,389	47,729,389
Utah	5,061,939	4,195,011	4,195,011
Vermont	3,636,206	2,975,632	2,975,632
Virgin Islands	338,947	336,681	336,681
Virginia	11,402,800	13,184,189	13,184,189
Washington	17,038,102	25,122,493	25,122,493
West Virginia	8,512,036	9,506,731	9,506,731
Wisconsin	28,163,921	20,143,798	20,143,798
Wyoming	1,608,617	1,291,205	1,291,205
Total, Budget Authority	1,011,757,257	1,000,000,000	1,000,000,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Payments to States for Foster Care and Adoption Assistance

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation language and explanation of language changes	D-2
Amount available for obligation	D-3
Summary of changes	D-4
Budget authority by activity	D-5
Budget authority by object	D-6
Authorizing legislation	D-7
Appropriation history table	D-8
Justification:	
A. General Statement	D-10
B. Foster Care	D-11
C. Adoption Assistance	D-15
D. Independent Living	D-18
E. State Tables	D-21

PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE

For making payments to States or other non-Federal entities, under title IV-E of the Social Security Act, \$4,445,000,000; and in addition, for the first quarter of fiscal year 1998, \$1,111,000,000.

Note.-A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Payments to States for Foster Care and Adoption Assistance

Amounts Available for Obligation

	1995 <u>Appropriation</u>	1996 <u>Policy</u> ¹	1997 <u>Estimate</u>
Appro-			
pria-			
tion.....	\$3,597,371,000	\$4,322,222,000	\$4,445,000,000
Unobli-			
gated			
balance,			
lapsing.....	- 194,296,000	---	---
Total			
Obliga-			
tions.....	\$3,403,075,000	\$4,322,222,000	\$4,445,000,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

Payments to States for Foster Care and Adoption Assistance

SUMMARY OF CHANGES

1996 Policy.....	\$4,322,222,000
1997 Request.....	4,445,000,000
Net change.....	+\$122,778,000

	1996 Current <u>Estimate Base</u>	Change <u>from Base</u>
<u>Increases:</u>		
A. <u>Increases:</u>		
<u>Built-in:</u>		
1. Increase in expected Foster Care costs.....	\$3,742,338,000	+\$64,774,000
2. Increase in expected Adoption Assistance payments	509,884,000	+58,004,000
Total Increases....		+\$122,778,000
Net change.....		+\$122,809,000

Payments to States for Foster Care and Adoption Assistance

Budget Authority by Activity

	1995 <u>Actual</u> ¹	1996 <u>Policy</u> ²	1997 <u>Estimate</u>
1. Foster Care.....	\$3,093,023,000	\$3,742,338,000	\$3,807,112,000
2. Adoption Assistance.	434,348,000	509,884,000	567,888,000
3. Independent Living.....	70,000,000	70,000,000	70,000,000
Total, Budget Authority.....	\$3,597,371,000	\$4,322,222,000	\$4,445,000,000

¹ Reflects \$35,000,000 reprogrammed from Foster Care to Adoption Assistance.

² Based on levels of the ninth CR, including an incremental policy adjustment.

Budget Authority by Object

	1996 <u>Policy</u> ¹	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Grants, subsidies and contributions	\$4,322,222,000	\$4,445,000,000	+\$122,778,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

Payments to States for Foster Care and Adoption Assistance

Authorizing Legislation

	1996 Amount <u>Authorized</u>	1996 <u>Policy</u> ¹	1997 Amount <u>Authorized</u>	1997 Budget <u>Request</u>
Foster Care [Sec. 470 of Title IV-E of the Social Security Act, as amended]	Indefinite	3,742,338,000	Indefinite	3,807,112,000
Independent Living [Sec. 470 and 477 of Title IV-E of the Social Security Act, as amended]	70,000,000	70,000,000	70,000,000	70,000,000
Adoption Assistance [Sec. 470 of Title IV-E of the Social Security Act, as amended]	Indefinite	509,884,000	Indefinite	567,888,000
Total Budget Authority	---	4,322,222,000	---	4,445,000,000
Appropriation against definite auth- orization	70,000,000	70,000,000	70,000,000	70,000,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

Payments to States for Foster Care and Adoption Assistance

APPROPRIATION HISTORY TABLE

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1986 ^f	740,994,000	745,019,000	810,412,000	777,092,000
1986 Sequester	-16,407,000	-16,407,000	-16,407,000	-16,407,000
1986 Rescission	-6,157,000	---	---	---
1987	817,837,000	1,005,223,000	889,717,000	939,567,000
1987 Supplemental	165,227,000	165,227,000	165,227,000	165,000,000
1988 ^h	682,040,000	811,178,000	811,178,000	811,178,000
1989	1,074,907,000	1,119,907,000	1,119,907,000	1,119,907,000
1989 Supplemental	598,679,000			532,275,000
1990	1,286,447,000	1,556,364,000	1,336,447,000	1,374,916,000
1991 ^g	2,471,283,000	2,583,929,000	2,583,929,000	2,583,929,000
1992 ^h	2,367,734,000	2,614,005,000	2,614,005,000	2,614,005,000
1993	2,988,668,000	2,988,668,000	2,924,014,000	2,924,014,000
1994	2,992,900,000	2,992,900,000	2,992,900,000	2,992,900,000
1995	3,440,871,000	3,597,371,000	3,597,371,000	3,597,371,000
1995 Sup.	26,291,000			
1996	4,307,842,000	4,307,842,000	4,322,238,000 _g	4,322,238,000 _g
1997	4,445,000,000			
1998	1,111,000,000			

Appropriation reflects withholding of \$145,000 pursuant to P.L. 99-190.

FY 1988 amounts reflect the transfer of four programs to the former Office of Human Development Services. Prior year amounts are non-comparable.

Budget Estimate to Congress included a legislative proposal to reduce Foster Care and Adoption Assistance costs by \$160,909,000.

Budget Estimate to Congress included a legislative proposal to reduce Foster Care administrative costs by \$246,631,000.

Senate Committee Mark.

Based on levels of the ninth CR, including an incremental policy adjustment.

Justification

Payments to States for Foster Care and Adoption Assistance

	1995 <u>Actual</u> ¹	1996 <u>Policy</u> ²	1997 <u>Estimate</u>
1. Foster Care.....	\$3,093,023,000	\$3,742,338,000	\$3,807,112,000
2. Adoption Assistance...	434,348,000	509,884,000	567,888,000
3. Independent Living.....	70,000,000	70,000,000	70,000,000
Total.....	\$3,597,371,000	\$4,322,222,000	\$4,445,000,000

General Statement

Payments to States for Foster Care and Adoption Assistance include those entitlement programs which assist States with the costs of: maintaining eligible children in foster care; preparing children for living on their own; and the adoption of children under special conditions. Administrative and training costs are also supported. The President's appropriation request of \$4,445,031,000 for this account represents current law requirements. No proposed law amounts are included.

Current law appropriation request..... \$4,445,000,000

¹ Reflects \$35,000,000 reprogrammed from Foster Care to Adoption Assistance.

² Based on levels of the ninth CR, including an incremental policy adjustment.

Foster Care

Authorizing legislation - Section 470, Title IV-E of the Social Security Act, as amended.

<u>1995</u> <u>Actual</u> ¹	<u>1996</u> <u>Policy</u> ²	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$3,093,023,000	\$3,742,338,000	\$3,807,112,000	+\$64,774,000

1997 Authorization.....Indefinite

Purpose and Method of Operations

This program provides funds to States to assist with: the costs of foster care maintenance payments for eligible children; administrative costs to manage the program, including costs for statewide automated information systems; and training of staff and foster and adopting parents. The purpose of the program is to help States provide proper care for children who need placement outside their homes, either in a foster family home or an institution.

This program is an annually appropriated entitlement program. Federal financial participation in State expenditures for foster care maintenance payments is provided at the Medicaid match rate for medical assistance payments, which varies among States from 50 percent to 79 percent. Federal financial participation for State administrative expenditures is made at a 50 percent match rate and at a 75 percent rate for the training of State or local agency personnel, foster parents, or staff of State licensed or approved institutions.

The 1980 amendments to the Social Security Act link the title IV-E programs, including Foster Care, to the Child Welfare Services State Grant Program (Title IV-B). The same State agency must administer, or supervise, the administration of the programs. The goal of both programs is to strengthen families in which children are at risk. The 1993 amendments to the Social Security Act created the new Family Preservation and Support Services Program. The same State agency must administer, or supervise the administration of all three programs. Taken together, these three programs provide a continuum of services to assist children and their families.

¹ Reflects \$35,000,000 reprogrammed from Foster Care to Adoption Assistance.

² Based on levels of the ninth CR, including an incremental policy adjustment.

During calendar year 1993, final regulations were published for the Adoption and Foster Care Analysis and Reporting System (AFCARS). This system requires that States collect and maintain data on all foster children and children adopted (except for some private adoptions), regardless of whether or not they receive Title IV-E benefits. Beginning in FY 1995, States are required to provide semi-annual reports on the status of these children.

The 1993 amendments to the Social Security Act set conditions for funding comprehensive statewide automated child welfare information systems. Under these amendments and the regulations implementing them, between FY 1994 and FY 1996 enhanced Federal funding is available at 75 percent for the planning, design, development, and installation of such a system, which must include AFCARS, and be able to interface with State child abuse and neglect systems and State eligibility systems for title IV-A.

The appropriations for Foster Care maintenance payments, administration, and training over the past five fiscal years are as follows:

1992	\$2,323,279,000 ^y
1993	\$2,574,214,000 ^y
1994	\$2,605,500,000
1995	\$3,093,203,000 ^y
1996	\$3,742,338,000 ^y

^y Includes \$118,476,000 specifically for prior year claims, and excludes \$18,865,000 reprogrammed for Adoption Assistance and Adoption Assistance prior year claims.

^y Reflects reprogramming of \$35,836,000 to Adoption Assistance.

^y Reflects a reprogramming of \$35,000,000 from Foster Care to Adoption Assistance.

^y Based on levels of the ninth CR, including an incremental policy adjustment.

Rationale for the Budget Request

The FY 1997 request for Foster Care is \$3,807,112,000. This request is based on current law estimates and includes funds for maintenance payments, state administration, and training.

The amount requested will provide Federal Financial Participation for an estimated average of 285,000 children per month.

The average monthly number of foster children for whom claims have been paid is increasing substantially due to new types of cases including: crack babies, children orphaned by AIDS,

increased payments to relative caregivers in some States, children staying in care longer because of the nature of their problems, and States making greater efforts to review their foster children more thoroughly for possible eligibility under title IV-E. This trend is expected to continue for at least the next few years.

In addition, \$1,111,000,000 is requested for the first quarter of FY 1998 to ensure timely first quarter grant awards.

Title IV-E-Foster Care

Program Data:

	<u>FY 1995</u> <u>Actual</u> ¹	<u>FY 1996</u> <u>Policy</u> ²	<u>FY 1997</u> <u>Request</u>
Service Grants:			
Formula	\$3,093,023,000	\$3,742,338,000	\$3,807,112,000
Discretionary	---	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$3,093,023,000	\$3,742,338,000	\$3,807,112,000
Number of Applicants	51	51	51
Number of Grants	51	51	51
New Starts:			
#	---	---	---
\$	---	---	---
Continuations:			
#	51	51	51
\$	\$3,093,023,000	\$3,742,338,000	\$3,807,112,000
Contracts:	---	---	---
#	---	---	---
\$	---	---	---

¹ Reflects \$35,000,000 reprogrammed from Foster Care to Adoption Assistance.

² Based on levels of the ninth CR, including an incremental policy adjustment.

Adoption Assistance

Authorizing legislation - Section 470, Title IV-E of the Social Security Act, as amended.

1995 <u>Actual</u> ¹	1996 <u>Policy</u> ²	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
\$423,348,000	\$509,884,000	\$567,888,000	+\$58,004,000

1997 Authorization.....Indefinite

Purpose and Method of Operations

The Adoption Assistance program was begun in FY 1981. It provides funds to States to assist in paying maintenance costs for adopted children with special needs. To receive adoption assistance benefits, a child must:

- o be a child with special needs, e.g., older; a member of a minority or sibling group; or have a physical, mental, or emotional disability;
- o have been receiving or be eligible to receive Aid to Families with Dependent Children benefits; or
- o have been receiving or be eligible to receive Supplemental Security Income benefits.

Funds are also used for the administrative costs of managing the program and training staff and adoptive parents. The goal of this program is to facilitate the placement of hard-to-place children in permanent adoptive homes and thus prevent long, inappropriate stays in foster care.

Adoption Assistance is an annually appropriated entitlement program. Federal financial participation in State maintenance expenditures is provided at the Medicaid match rate for medical assistance payments, which varies among States from 50 percent to 79 percent. State adoption subsidy payments made on behalf of individual children also vary from State to State but may not exceed comparable foster family care rates. State administrative

¹ Reflects \$35,000,000 reprogrammed from Foster Care to Adoption Assistance.

² Based on levels of the ninth CR, including an incremental policy adjustment.

costs are matched at 50 percent match rate and training for State and county employees and adoptive parents at 75 percent match rate.

The number of adopted children subsidized by this program and the level of Federal reimbursement have increased significantly as permanent homes are found for more children. Over the past five years, the average monthly number of children for whom payments were made has more than doubled - from just over 60,000 to over 131,000.

The appropriations for Adoption Assistance payments, administration, and training over the past five fiscal years are as follows:

FY 1992.....	220,726,000	[#]
FY 1993.....	273,386,486	[#]
FY 1994.....	317,400,000	
FY 1995.....	423,348,000	^c
FY 1996.....	509,884,000	^d

[#] Funds available after reprogramming from Foster Care of \$6,941,000 for the regular program and \$11,924,000 for prior year claims.

^b Includes \$35,836,000 reprogrammed from Title IV-E Foster Care, and excludes \$6,413,514 in lapsed funds, and \$2,000 in payments reported after the Treasury Annual Report had been completed.

^c Reflects a reprogramming of \$35,000,000 from Foster Care to Adoption Assistance.

^d Based on levels of the ninth CR, including an incremental policy adjustment.

Rationale for the Budget Request

The FY 1997 request for Adoption Assistance is \$567,888,000. This request is based on current law estimates, including maintenance payments, state administration, and training.

The amount requested will provide Federal Financial Participation for an estimated average 131,200 children per month.

Title IV-E-Adoption Assistance

Program Data:

	<u>FY 1995</u> <u>Actual</u> ¹	<u>FY 1996</u> <u>Policy</u> ²	<u>FY 1997</u> <u>Request</u>
Service Grants:			
Formula	\$423,348,000	\$509,884,000	\$567,888,000
Discretionary	---	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$423,348,000	\$509,884,000	\$567,888,000
Number of Applicants	51	51	51
Number of Grants	51	51	51
New Starts:	---	---	---
#	---	---	---
\$	---	---	---
Continuations:			
#	51	51	51
\$	\$423,348,000	\$509,884,000	\$567,888,000
Contracts:	---	---	---
#	---	---	---
\$	---	---	---

¹ Reflects \$35,000,000 reprogrammed from Foster Care to Adoption Assistance.

² Based on levels of the ninth CR, including an incremental policy supplemental.

Independent Living

Authorizing Legislation - Sections 470 and 477 of Title IV-E, of the Social Security Act.

<u>1995 Actual</u>	<u>1996 Policy¹</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$70,000,000	\$70,000,000	\$70,000,000	---

1997 Authorization..... \$70,000,000

Purpose and Method of Operations

This program provides services to foster children who are 16 or older to help them to make the transition to independent living by helping them earn a high school diploma or receive vocational training, receive training in daily living skills such as budgeting, locating housing, career planning and job finding, or otherwise make the transition to independent living.

Funds are awarded to States in the form of grants. Each State is eligible to receive a portion of the funds appropriated that is equal to each State's proportion of the national total of foster children that received maintenance payments under the IV-E Foster Care program in fiscal year 1984.

In order to be awarded Federal funds in addition to their share of an initial \$45,000,000, States must match the additional Federal funds dollar for dollar. In the aggregate, States are expected to provide the match necessary to receive the additional funds.

Appropriations for Independent Living over the past five years have been:

1992.....\$70,000,000
 1993.....\$70,000,000
 1994.....\$70,000,000
 1995.....\$70,000,000
 1996.....\$70,000,000 ,

¹ Based on levels in the ninth CR, including an incremental policy adjustment.

Rationale from the Budget Request

The FY 1997 request for this program is \$70,000,000, the same level as the FY 1996 annualized amount available under the ninth Continuing Resolution, and the amount authorized for FY 1997. This program is an entitlement program with a fixed funding level.

Title IV-E-Independent Living

Program Data:

	<u>FY 1995</u> <u>Actual</u>	<u>FY 1996</u> <u>Policy¹</u>	<u>FY 1997</u> <u>Request</u>
Service Grants:			
Formula	\$70,000,000	\$70,000,000	\$70,000,000
Discretionary	---	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$70,000,000	\$70,000,000	\$70,000,000
Number of Applicants	51	51	51
Number of Grants	51	51	51
New Starts:			
#	---	---	---
\$	---	---	---
Continuations:			
#	51	51	51
\$	\$70,000,000	\$70,000,000	\$70,000,000
Contracts:			
#	---	---	---
\$	---	---	---

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

STATE TABLES

FOSTER CARE

State	1995 Actual	1996 Policy	1997 Estimate
Alabama	\$8,638,104	\$11,152,671	\$11,345,799
Alaska	8,200,720	10,587,964	10,771,313
Arizona	33,875,462	43,736,669	44,494,045
Arkansas	21,185,972	27,353,246	27,826,915
California	569,065,443	734,721,406	747,444,367
Colorado	25,907,642	33,449,403	34,028,636
Connecticut	50,272,934	64,907,475	66,031,459
Delaware	5,054,352	6,525,683	6,638,686
Dist of Col	19,139,898	24,711,556	25,139,479
Florida	64,873,785	83,758,659	85,209,084
Georgia	25,339,727	32,716,167	33,282,703
Hawaii	8,535,988	11,020,829	11,211,674
Idaho	4,563,992	5,892,578	5,994,618
Illinois	201,853,669	260,613,631	265,126,603
Indiana	70,543,259	91,078,527	92,655,708
Iowa	13,889,795	17,933,139	18,243,682
Kansas	23,103,957	29,829,560	30,346,110
Kentucky	43,103,578	55,651,106	56,614,801
Louisiana	32,809,829	42,360,829	43,094,379
Maine	15,162,325	19,576,105	19,915,099
Maryland	51,449,492	66,426,531	67,576,820
Massachusetts	92,855,999	119,886,546	121,962,587
Michigan	94,691,160	122,255,925	124,372,996
Minnesota	33,501,225	43,253,491	44,002,500
Mississippi	5,692,200	7,349,210	7,476,474
Missouri	32,018,472	41,339,106	42,054,964
Montana	9,552,365	12,333,075	12,546,644
Nebraska	15,592,289	20,131,232	20,479,839
Nevada	2,682,930	3,463,936	3,523,920
New Hampshire	8,481,026	10,949,868	11,139,483

FOSTER CARE (continued)

State	1995 Actual	1996 Policy	1997 Estimate
New Jersey	29,216,261	37,721,167	38,374,373
New Mexico	6,609,943	8,534,109	8,681,892
New York	571,135,249	737,393,736	750,131,972
North Carolina	32,376,029	41,800,749	42,524,600
North Dakota	7,174,221	9,262,649	9,423,048
Ohio	122,227,412	157,808,029	160,540,746
Oklahoma	26,309,471	33,968,205	34,556,423
Oregon	33,315,860	43,014,166	43,759,030
Pennsylvania	210,019,679	271,156,781	275,852,326
Rhode Island	7,475,756	9,651,962	9,819,102
South Carolina	12,670,104	16,358,394	16,641,667
South Dakota	2,903,802	3,749,104	3,814,026
Tennessee	24,276,144	31,342,973	31,885,730
Texas	111,011,088	143,326,613	145,808,559
Utah	9,216,854	11,899,897	12,105,964
Vermont	8,846,545	11,421,790	11,619,578
Virginia	18,956,895	24,475,281	24,899,112
Washington	20,433,899	26,382,243	26,839,097
West Virginia	5,550,665	7,166,473	7,290,573
Wisconsin	46,643,408	60,221,387	61,264,224
Wyoming	554,696	716,169	728,571
Case Review			
Grant	300,000	---	---
Lapse	194,161,430		
Total Budget			
Authority	\$3,093,023,000 ¹	\$3,742,338,000 ²	\$3,807,112,000

¹ Excludes \$35,000,000 reprogrammed to Adoption Assistance.

² Based on levels of the ninth CR, including an incremental policy adjustment.

ADOPTION ASSISTANCE

State	1995 Actual	1996 Policy	1997 Estimate
Alabama	\$1,848,511	\$2,170,651	\$2,417,583
Alaska	1,313,194	1,542,044	1,717,466
Arizona	5,577,281	6,549,234	7,294,269
Arkansas	2,127,736	2,498,537	2,782,768
California	51,873,101	60,913,026	67,842,443
Colorado	3,417,928	4,013,570	4,470,151
Connecticut	8,100,269	9,511,903	10,593,969
Delaware	586,702	688,947	767,321
Dist of Col	1,944,251	2,283,076	2,542,796
Florida	16,259,711	19,093,291	21,265,328
Georgia	4,678,501	5,493,823	6,118,796
Hawaii	798,489	937,642	1,044,307
Idaho	772,365	906,965	1,010,141
Illinois	18,896,821	22,189,970	24,714,283
Indiana	5,674,110	6,662,937	7,420,908
Iowa	5,380,112	6,317,704	7,036,401
Kansas	3,148,499	3,697,188	4,117,777
Kentucky	3,731,789	4,382,128	4,880,635
Louisiana	10,540,366	12,377,235	13,785,260
Maine	3,193,920	3,750,524	4,177,181
Maryland	3,673,763	4,313,990	4,804,746
Massachusetts	11,231,068	13,188,306	14,688,597
Michigan	33,207,488	38,994,557	43,430,546
Minnesota	5,035,149	5,912,624	6,585,240
Mississippi	595,723	699,540	779,119
Missouri	6,521,186	7,657,633	8,528,759
Montana	1,145,430	1,345,044	1,498,055
Nebraska	1,914,119	2,247,693	2,503,388
Nevada	598,975	703,358	783,372
New Hampshire	892,890	1,048,494	1,167,770

ADOPTION ASSISTANCE (continued)

State	1995 Actual	1996 Policy	1997 Estimate
New Jersey	8,311,138	9,759,520	10,869,755
New Mexico	2,382,427	2,797,613	3,115,867
New York	102,927,370	120,864,517	134,613,975
North Carolina	4,167,501	4,893,771	5,450,483
North Dakota	545,106	640,102	712,919
Ohio	33,503,631	39,342,308	43,817,858
Oklahoma	3,142,199	3,689,790	4,109,538
Oregon	4,061,678	4,769,507	5,312,082
Pennsylvania	9,898,814	11,623,880	12,946,204
Rhode Island	3,275,042	3,845,784	4,283,277
South Carolina	4,311,767	5,063,179	5,639,162
South Dakota	691,501	812,009	904,382
Tennessee	3,994,645	4,690,792	5,224,413
Texas	17,987,684	21,122,398	23,525,265
Utah	1,426,779	1,675,424	1,866,019
Vermont	2,206,241	2,590,723	2,885,441
Virginia	3,105,912	3,647,179	4,062,079
Washington	3,245,929	3,811,597	4,245,201
West Virginia	560,840	658,578	733,497
Wisconsin	9,746,543	11,445,073	12,747,055
Wyoming	41,406	48,622	54,153
Lapse	134,400	---	---
Total Budget Authority	\$434,348,000 ¹	\$509,884,000 ²	\$567,888,000

¹ Reflects \$35,000,000 reprogrammed from Foster Care to Adoption Assistance.

² Based on levels of the ninth CR, including an incremental policy adjustment.

INDEPENDENT LIVING

State	1995 Actual	1996 Policy	1997 Estimate
Alabama	\$1,044,321	\$1,038,490	\$1,038,490
Alaska	13,105	13,032	13,032
Arizona	349,716	347,763	347,763
Arkansas	272,461	270,940	270,940
California	12,551,856	12,481,777	12,481,777
Colorado	830,491	825,854	825,854
Connecticut	758,753	754,518	754,518
Delaware	204,174	203,034	203,034
Dist of Col	927,342	1,091,992	1,091,992
Florida	992,587	987,045	987,045
Georgia	1,105,021	1,098,852	1,098,852
Hawaii	17,934	17,834	17,834
Idaho	107,605	107,004	107,004
Illinois	2,832,910	2,817,094	2,817,094
Indiana	1,019,970	1,019,970	1,019,970
Iowa	452,492	449,966	449,966
Kansas	721,505	717,477	717,477
Kentucky	791,557	791,557	791,557
Louisiana	1,358,131	1,358,131	1,358,131
Maine	569,065	565,888	565,888
Maryland	1,245,046	1,238,095	1,238,095
Massachusetts	639,422	635,852	635,852
Michigan	4,195,218	4,171,796	4,171,796
Minnesota	1,148,477	1,142,066	1,142,066
Mississippi	517,332	514,444	514,444
Missouri	1,302,297	1,295,026	1,295,026
Montana	244,189	244,190	244,190
Nebraska	438,007	435,562	435,562
Nevada	154,510	153,647	153,647
New Hampshire	322,124	320,326	320,326

INDEPENDENT LIVING (continued)

State	1995 Actual	1996 Policy	1997 Estimate
New Jersey	2,310,749	2,297,848	2,297,848
New Mexico	208,312	207,149	207,149
New York	11,651,008	11,585,958	11,585,958
North Carolina	1,051,218	1,045,349	1,045,349
North Dakota	193,136	192,058	192,058
Ohio	2,877,055	2,860,992	2,860,992
Oklahoma	623,557	620,076	620,076
Oregon	930,800	930,799	930,799
Pennsylvania	4,664,267	4,638,225	4,638,225
Rhode Island	316,608	314,840	314,840
South Carolina	582,860	579,606	579,606
South Dakota	193,430	193,430	193,430
Tennessee	782,205	777,838	777,838
Texas	1,852,048	1,841,708	1,841,708
Utah	203,484	202,348	202,348
Vermont	297,293	295,633	295,633
Virginia	1,361,561	1,361,561	1,361,561
Washington	829,801	825,168	825,168
West Virginia	335,123	521,302	521,302
Wisconsin	1,563,032	1,554,305	1,554,305
Wyoming	44,835	44,585	44,585
Total Budget Authority	\$70,000,000	\$70,000,000 ¹	\$70,000,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

In his State of the Union message and in the FY 1997 budget the President continues to encourage enactment of a bipartisan welfare reform bill. If a bill is enacted, as proposed by the President in his FY 1997 Budget, this program would be affected and the current law numbers that appear would change.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Social Services Block Grant

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation language and explanation of language changes .	E-3
Amount available for obligation.	E-4
Summary of changes	E-5
Budget authority by activity	E-6
Budget authority by object	E-6
Authorizing legislation.	E-7
Appropriation history table.	E-8
Justification:	
A. General Statement	E-9
B. Social Services Block Grant	E-10
State Table	E-13

SOCIAL SERVICES BLOCK GRANT

For making grants to States pursuant to section 2002 of the Social Security Act, \$2,800,000,000.

Note. A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Social Services Block Grant

Amounts Available for Obligation

	1995 <u>Actual</u>	1996 <u>Policy a/</u>	1997 <u>Estimate</u>
Appropriation:			
Annual.....	\$2,800,000,000	\$2,800,000,000	\$2,800,000,000
Offsetting			
collections from:			
Trust funds...	6,000,000	-0-	-0-
Unobligated balance			
start of year ...	1,000,000,000	360,000,000	-0-
Unobligated balance			
end of year	<u>-360,000,000</u>	<u>-0-</u>	<u>-0-</u>
Total obligations	\$3,446,000,000	\$3,160,000,000	\$2,800,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

SUMMARY OF CHANGES

1996 Policy	\$2,800,000,000
1996 Estimate	<u>\$2,800,000,000</u>
Net Change	-0-

Budget Authority by Activity
(Dollars in thousands)

	1995 <u>Actual</u>	1996 <u>Policy a/</u>	1997 <u>Estimate</u>
Social Services			
Block Grant.....	\$2,800,000	\$2,800,000	\$2,800,000
Total Budget Authority.....	\$2,800,000	\$2,800,000	\$2,800,000
Obligations.....	\$3,446,000	\$3,160,000	\$2,800,000

Budget Authority by Object

Grants, subsidies and contributions	\$2,800,000	\$2,800,000	\$2,800,000
Total Budget Authority.....	\$2,800,000	\$2,800,000	\$2,800,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

Authorizing Legislation

	1996 Amount <u>Authorized</u>	1996 Policy	1997 Amount <u>Authorized</u>	1997 <u>Estimate</u>
Social Services Block Grant (Sec. 2003, Title XX of the Social Security Act, as amended.)	\$2,800,000,000	\$2,800,000,000	\$2,800,000,000	\$2,800,000,000

APPROPRIATION HISTORY TABLE
Social Services Block Grant

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1987	2,700,000,000	2,700,000,000	2,700,000,000	2,700,000,000
1988	2,700,000,000	2,700,000,000	2,700,000,000	2,700,000,000
1989	2,700,000,000	2,700,000,000	2,700,000,000	2,700,000,000
1990	2,700,000,000	2,700,000,000	2,700,000,000	2,700,000,000
1990 Supple- mental	---	100,000,000	100,000,000	100,000,000
1990 Sequester	---	---	---	-37,800,000
1991	2,800,000,000	2,800,000,000	2,800,000,000	2,800,000,000
1992	2,800,000,000	2,800,000,000	2,800,000,000	2,800,000,000
1993	2,800,000,000	2,800,000,000	2,800,000,000	2,800,000,000
1994	2,800,000,000	2,800,000,000	3,800,000,000	3,800,000,000
1994 Supple- men- tal	7,000,000	7,000,000	7,000,000	7,000,000
1995	2,800,000,000	2,800,000,000	2,800,000,000	2,800,000,000
1996	2,800,000,000	2,800,000,000	2,520,000,000 ^{a/}	2,800,000,000 ^{b/}
1997	2,800,000,000			

^{a/} Senate Committee Mark.

^{b/} Based on levels of the ninth CR, including an incremental policy adjustment.

SOCIAL SERVICES BLOCK GRANT

Justification

	1995 Actual	1996 Policy <u>a/</u>	1997 Estimate	Increase or Decrease
Block Grant	\$2,800,000,000	\$2,800,000,000	\$2,800,000,000	-0-

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

General Statement

The Social Services Block Grant is designed to promote social and economic needs to prevent, reduce or eliminate dependency; achieve or maintain self-sufficiency; prevent neglect, abuse or exploitation of children and adults; prevent or reduce inappropriate institutional care; and secure admission or referral for institutional care when other forms of care are not appropriate.

The President's appropriation request of \$2,800,000,000 for this account represents current law requirements. No proposed law amounts are included.

Social Services Block Grant

Authorizing Legislation - Section 2003 of Title XX of the Social Security Act, as amended.

<u>1995</u> <u>Enacted</u>	<u>1996</u> <u>Policy a/</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$2,800,000,000	\$2,800,000,000	\$2,800,000,000	\$-0-

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization..... \$2,800,000,000

Purpose and Method of Operations

The Social Services Block Grant is an appropriated entitlement program. Social Services Block Grant funds are distributed to Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Commonwealth of the Northern Marianas, based on the same ratio allotted to them in 1981 to the total 1981 appropriation. The remainder is distributed to the States and the District of Columbia in proportion to the percentage of their population to the National population. There are no matching requirements.

This program encourages each State, as far as practicable under the conditions in the State, to furnish a variety of social services best suited to the needs of individuals residing within the State.

The five year funding history for this program is:

1992	\$2,800,000,000
1993	\$2,800,000,000
1994	\$2,807,000,000*
1995	\$2,800,000,000
1996	\$2,800,000,000

* Includes real transfer of \$7,000,000 from Public Health Services for earthquake supplemental.

Rationale for the Budget Request

The FY 1997 request for the Social Services Block Grant is \$2,800,000,000. In his State of the Union message and in the FY 1997 budget the President continues to encourage enactment of a bipartisan welfare reform bill. If a bill is enacted, as proposed by the President in his FY 1997 Budget, this program

would be affected and the current law numbers that appear would change.

Name of Program: Social Services Block Grant

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	\$2,800,000,000	\$2,800,000,000	\$2,800,000,000
Discretionary	---	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$2,800,000,000	\$2,800,000,000	\$2,800,000,000
Number of Applicants	57	57	57
Number of Grants	57	57	57
New Starts:			
#	57	57	57
\$	2,800,000,000	2,800,000,000	2,800,000,000
Continuations:			
#	---	---	---
\$	---	---	---
Contracts:			
#	---	---	---
\$	---	---	---

STATE TABLES

SOCIAL SERVICES BLOCK GRANT

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
Alabama	45,146,563	45,202,466	45,122,270
Alaska	6,407,406	6,477,545	6,481,179
Arizona	41,828,247	42,492,693	43,582,187
Arkansas	26,186,317	26,169,280	26,234,873
California	336,929,151	336,951,078	336,155,028
Colorado	37,876,831	38,498,207	39,100,976
Connecticut	35,813,799	35,378,190	35,026,175
Delaware	7,520,789	7,567,931	7,550,681
D.C.	6,429,237	6,250,831	6,096,159
Florida	147,228,444	147,677,222	149,227,549
Georgia	73,690,631	74,675,294	75,453,333
Hawaii	12,661,996	12,663,600	12,609,423
Idaho	11,646,853	11,875,499	12,117,452
Illinois	126,958,336	126,279,733	125,687,820
Indiana	61,803,637	61,677,021	61,517,728
Iowa	30,694,424	30,379,684	30,256,198
Kansas	27,539,840	27,324,443	27,315,069
Kentucky	40,987,753	40,905,695	40,929,824
Louisiana	46,794,806	46,368,424	46,148,991
Maine	13,480,659	13,376,130	13,261,819
Maryland	53,573,340	53,601,682	53,539,247
Mass.	65,471,249	64,904,998	64,608,588
Michigan	103,009,700	102,323,614	101,559,865
Minnesota	48,901,500	48,765,115	48,844,135
Mississippi	28,533,152	28,533,584	28,544,996
Missouri	56,684,261	56,505,781	56,448,291
Montana	8,994,383	9,068,563	9,154,933
Nebraska	17,530,314	17,349,024	17,358,010
Nevada	14,484,886	14,995,516	15,582,637
New Hampshire	12,127,135	12,156,192	12,160,232
New Jersey	85,020,934	85,060,957	84,533,401
New Mexico	17,257,427	17,446,187	17,689,555
New York	197,778,187	196,453,134	194,317,733
North Carolina	74,694,858	74,977,580	75,613,758
North Dakota	6,942,267	6,866,197	6,823,420

SOCIAL SERVICES BLOCK GRANT (continued)

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
Ohio	120,245,295	119,737,413	118,736,060
Oklahoma	35,060,629	34,881,578	34,844,360
Oregon	32,495,483	32,733,192	33,004,817
Pennsylvania	131,084,400	129,982,730	128,896,325
Rhode Island	10,970,091	10,806,704	10,662,930
South Carolina	39,328,595	39,329,492	39,186,536
South Dakota	7,760,930	7,729,870	7,711,106
Tennessee	54,839,539	55,048,334	55,346,704
Texas	192,724,304	194,661,013	196,552,992
Utah	19,789,826	20,080,388	20,406,089
Vermont	6,221,843	6,229,239	6,203,109
Virginia	69,608,229	70,076,237	70,073,740
Washington	56,062,077	56,732,495	57,143,467
West Virginia	19,778,910	19,648,552	19,486,318
Wisconsin	54,653,975	54,389,783	54,352,068
Wyoming	5,097,545	5,084,873	5,090,827
Indians Tribes	-0-	-0-	-0-
Territories	15,649,017	15,649,017	15,649,017
Total	\$2,800,000,000	\$2,800,000,000	\$2,800,000,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Family Preservation and Support

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation language	F-2
Amount available for obligation.	F-3
Summary of changes	F-4
Budget authority by activity	F-5
Budget authority by object	F-6
Authorizing legislation.	F-7
Appropriation history table.	F-8
Justification:	
A. General Statement	F-9
B. Family Support and Preservation	F-10
C. State Tables.	F-14

FAMILY PRESERVATION AND SUPPORT

For carrying out Section 430 of the Social Security Act,
\$240,000,000.

Note. -A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 Administration for Children and Families
 FAMILY PRESERVATION AND SUPPORT

Amounts Available for Obligation

	1995 <u>Actual</u>	1996 a/ <u>Policy</u>	1997 <u>Estimate</u>
Appropriation: Annual.....	\$150,000,000	\$225,000,000	\$240,000,000
Unobligated balance, expiring	<u>-118,000</u>	<u>-0-</u>	<u>-0-</u>
Total obligations	\$149,882,000	\$225,000,000	\$240,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

SUMMARY OF CHANGES

1996 Policy.....	\$225,000,000
1997 Estimate.....	<u>\$240,000,000</u>
Net Change.....	+\$15,000,000

	<u>1996 Policy</u>	<u>Change from Base</u>
<u>Increase</u>		
A. <u>Program</u>		
1. Increase of program funds for Family Preservation & Support	\$225,000,000	+\$15,000,000
Total Increase		+\$15,000,000
Net Change		+\$15,000,000

Budget Authority by Activity

	1995 <u>Actual</u>	1996 <u>a/</u> <u>Policy</u>	1997 <u>Estimate</u>
Grants to States.....	\$144,000,000	\$219,000,000	\$234,000,000
Training & Technical Assistance & Evaluation...	<u>6,000,000</u>	<u>6,000,000</u>	<u>6,000,000</u>
Total Budget Authority....	\$150,000,000	\$225,000,000	\$240,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

Budget Authority by Object

	1996 ^a / <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Consulting Services	\$6,000,000	\$6,000,000	- 0 -
Grants, subsidies & contribu tions	<u>\$219,000,000</u>	<u>\$234,000,000</u>	<u>+\$15,000,000</u>
Total Budget Authority	\$225,000,000	\$240,000,000	+\$15,000,000

^a/ Based on levels of the ninth CR, including an incremental policy adjustment.

Authorizing Legislation

	1996 Amount <u>Authorized</u>	1996 Policy	1997 Amount <u>Authorized</u>	1997 Estimate
Family Preservation and Support - Section 430 (a) & (b) of the Social Security Act, as amended.	\$225,000,000	\$225,000,000	\$240,000,000	\$240,000,000

APPROPRIATION HISTORY TABLE
Family Preservation and Support

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1994	60,000,000	-0-	60,000,000	60,000,000
1995	150,000,000	150,000,000	150,000,000	150,000,000
1996	225,000,000	225,000,000	225,000,000 ^{a/}	225,000,000 ^{b/}
1997	240,000,000			

^{a/} Senate Committee Mark.

^{b/} Based on levels of the ninth CR, including an incremental policy adjustment.

Justification

Family Preservation and Support

	1996 <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Family Preservation and Support	\$225,000,000	\$240,000,000	+\$15,000,000
Total, Budget Authority	\$225,000,000	\$240,000,000	+\$15,000,000

General Statement

The Family Preservation and Support program is a capped entitlement program. Its purpose is to encourage and enable each State to develop and establish, or expand, and to operate a program of family preservation services and community-based family support services.

"Family preservation services" are services designed to help families alleviate crises; maintain the safety of children in their own homes; support families who are preparing to reunify or adopt, and assist families to obtain services and other support necessary to address their multiple needs in a culturally and community sensitive manner.

"Family support services" are primarily community-based preventive activities designed to promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children; enable families to use other resources and opportunities available in the community; and create supportive networks to enhance child-rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families.

Both family support and family preservation services are based on a common set of principles or characteristics which help assure their responsiveness and effectiveness for children and their families.

The President's appropriation request of \$240,000,000 for this account represents current law requirements. No proposed law amounts are included.

Family Preservation and Support

Authorizing Legislation - Subpart 2 Title IV-B of the Social Security Act.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$150,000,000	\$225,000,000	\$240,000,000	+\$15,000,000

1997 Authorization..... \$240,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

Purpose and Method of Operations:

The Family Preservation and Support program provides grants to States to develop and expand two types of services: (1) innovative child welfare services including family preservation, family reunification and other services and (2) community-based family support services. States will be required to use a portion of these funds for each group of services.

One percent of the amount appropriated is reserved for allotment to tribal organizations or Indian tribes that have submitted a plan and whose allotment is greater than \$10,000. Tribal allotments are based on the number of children in the tribe relative to the number of children in all tribes with approved plans. The allotment to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands and American Samoa is determined by a formula. The remaining funds are distributed to States based on the State's share of children in all States receiving food stamp benefits. States are entitled to payments equal to their allotments, for use in paying not more than 75 percent of the costs of activities under the approved State plan. The remaining 25 percent of costs must be paid with funds from non-Federal sources.

Funds provided to the States will be used to provide both preventive services (family support) and more intensive services for families at risk or in crisis (family preservation services). States will carry out a comprehensive planning process, consulting with a broad range of public and private agencies providing services to families, as well as with parents and families themselves, to ensure that services are coordinated and

that funds are spent in a manner responsive to the needs of families.

Funding for the Family Preservation and Support program during the last five years has been as follows:

1992.....	\$-0-
1993.....	\$-0-
1994.....	\$60,000,000
1995.....	\$150,000,000
1996.....	\$225,000,000

Rationale for the Budget Request:

The FY 1997 request for the Family Preservation and Support program is \$240,000,000. These funds will support activities conducted by States and certain Indian Tribes in the third year under the five-year plans developed with funding supplied in FY 1994. The funds will be primarily devoted to the development and delivery of family preservation and support services. In FY 1997, from the \$15 million increase, \$10 million will be reserved for State court assessment activities and \$150,000 will be reserved for Indian Tribes, as required by the authorizing legislation.

Name of Program: Family Preservation and Support

Program Data:

	1995 <u>Enacted</u>	1996 <u>Policy</u>	1997 <u>Request</u>
Service Grants: Formula	\$139,000,000	\$209,000,000	\$224,000,000*
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	2,000,000	2,000,000	2,000,000
Evaluation	4,000,000	4,000,000	4,000,000
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	\$145,000,000	\$215,000,000	\$230,000,000*
Number of Applicants	90	94	109
Number of Grants	90	94	109
New Starts:			
#	90	4	15
\$	139,000,000	40,000	150,000
Continuations:			
#	--	90	94
\$	--	208,960,000	223,850,000
Contracts:			
#	4	4	4
\$	6,000,000	6,000,000	6,000,000

* Does not include \$10,000,000 for Court Improvement Projects.

Name of Program: Court Improvement Program

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	\$5,000,000	\$10,000,000	\$10,000,000
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	\$5,000,000	\$10,000,000	\$10,000,000
Number of Applicants	48	48	48
Number of Grants	48	48	48
New Starts:			
#	48	--	--
\$	5,000,000	--	--
Continuations:			
#	--	48	48
\$	--	10,000,000	10,000,000
Contracts:			
#	--	--	--
\$	--	--	--

STATE TABLES

FAMILY PRESERVATION AND SUPPORT

State	1995 ENACTED	1996 POLICY	1997 REQUEST
Alabama	\$2,980,232	\$4,592,549	\$4,903,439
Alaska	265,777	442,893	463,043
Arizona	2,512,207	3,878,153	4,138,667
Arkansas	1,476,252	2,293,879	2,443,567
California	16,892,469	25,881,155	27,692,579
Colorado	1,575,585	2,448,214	2,607,977
Connecticut	1,159,126	1,811,617	1,926,761
Delaware	332,233	544,140	571,487
Dist. of Columbia	544,482	867,311	917,687
Florida	6,425,918	9,869,023	10,546,935
Georgia	3,849,940	5,926,658	6,329,663
Hawaii	431,418	875,105	925,481
Idaho	373,451	569,580	609,880
Illinois	6,157,708	9,459,261	10,108,387
Indiana	2,361,966	3,653,666	3,896,908
Iowa	1,118,307	1,748,978	1,849,804
Kansas	983,608	1,542,909	1,639,342
Kentucky	2,697,629	4,160,335	4,440,999
Louisiana	4,637,313	7,121,427	7,610,790
Maine	668,724	1,058,799	1,122,126
Maryland	1,929,367	2,991,122	3,188,307
Massachusetts	2,413,455	3,731,312	3,980,312
Michigan	5,666,096	8,704,023	9,301,334
Minnesota	1,675,341	2,603,395	2,773,233
Mississippi	2,866,102	4,414,953	4,714,328
Missouri	2,865,876	4,420,834	4,718,770
Montana	400,091	648,192	682,735
Nebraska	644,909	1,023,835	1,084,286
Nevada	469,160	754,665	796,405
New Hampshire	307,958	508,256	532,724

FAMILY PRESERVATION AND SUPPORT (continued)

State	1995 ENACTED	1996 POLICY	1997 REQUEST
New Jersey	2,837,323	4,382,727	4,676,345
New Mexico	1,179,006	1,838,711	1,956,734
New York	9,883,345	15,156,312	16,204,125
North Carolina	2,900,306	4,477,028	4,777,843
North Dakota	318,915	523,837	549,744
Ohio	6,820,228	10,467,655	11,188,746
Oklahoma	1,761,370	2,731,123	2,911,036
Oregon	1,318,986	2,055,342	2,187,758
Pennsylvania	5,668,459	8,645,419	9,257,123
Rhode Island	533,717	852,114	901,050
South Carolina	2,030,348	3,142,420	3,351,119
South Dakota	386,256	626,854	659,958
Tennessee	3,290,853	5,068,134	5,412,128
Texas	13,098,351	20,066,419	21,459,665
Utah	796,268	1,256,890	1,333,173
Vermont	331,638	542,950	570,297
Virginia	2,337,633	3,617,665	3,858,029
Washington	2,358,895	3,647,524	3,890,766
West Virginia	1,458,808	2,265,323	2,413,571
Wisconsin	2,078,403	3,219,531	3,432,548
Wyoming	186,726	284,791	304,941
American Samoa	122,095	186,217	199,393
Guam	219,181	334,290	357,943
Northern Mariana	96,047	146,489	156,854
Puerto Rico	3,498,785	5,336,276	5,713,843
Virgin Islands	188,397	287,339	307,670
Indian Tribe			
Set aside	1,498,773	2,287,771	2,449,642
Discretionary	3,000,000	3,000,000	3,000,000
Discretionary	3,118,188	-0-	-0-
Total, Budget Authority	\$150,000,000	\$225,000,000	\$240,000,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Low Income Home Energy Assistance

<u>FY 1997 Budget</u>	Page
Appropriation language and explanation of language changes	G-2
Amounts available for obligation	G-3
Summary of changes	G-4
Budget authority by activity	G-5
Budget authority by object	G-6
Authorizing legislation	G-7
Appropriation history table	G-9
Justification:	
A. General Statement.	G-13
B. Program	G-15
C. Contingency Funds.	G-18
D. State Tables	G-22

LOW INCOME HOME ENERGY ASSISTANCE

For making payments under title XXVI of the Omnibus Budget Reconciliation Act of 1981: (1) \$1,000,000,000, to be available in the period October 1, 1996 through September 30, 1997; (2) an additional \$300,000,000, which is hereby designated by Congress to be emergency requirements pursuant to section 251(b)(2)(D)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and which shall be made available only after submission to Congress of a formal budget request by the President that includes designation of the entire amount of the request as an emergency requirement as defined in that Act; and (3) \$1,000,000,000, to be available for the period October 1, 1997 through September 30, 1998.

Note.-A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

LOW INCOME HOME ENERGY ASSISTANCE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Low Income Home Energy Assistance Program

Amounts Available for Obligation

	<u>1995 Actual</u>	<u>1996 Policy¹</u>	<u>1997 Estimate</u>
Advance Appropriation ...	1,319,204,000	1,319,204,000	1,000,000,000
Emergency Supplemental	100,000,000	---	---
Emergency Fund	(600,000,000) ²	(300,000,000)	(300,000,000)
Enacted rescission...	---	-319,204,000	---
Subtotal, adjusted budget authority.....	1,419,204,000	1,000,000,000	1,000,000,000
P.L. 103-333 reductions	-1,521	---	---
Unobligated balance, lapsing.....	-76,469	---	---
Total obligations..	\$1,419,126,010	\$1,000,000,000	\$1,000,000,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

² Of the \$600,000,000 made available contingent on the designation by the President as emergency requirements, \$100,000,000 was in fact designated as emergency requirements and appropriated in an emergency supplemental, P.L. 104-19.

SUMMARY OF CHANGES

Regular Program

1996 Appropriation.....	\$1,319,204,000
1996 Rescission.....	<u>-319,204,000</u>
1996 Policy.....	\$1,000,000,000

1997 Appropriation	
Appropriated in FY 1996.....	<u>\$1,000,000,000</u>

Net change.....	\$---
-----------------	-------

1998 Appropriation	
Requested in FY 1997.....	\$1,000,000,000

Emergency Funds

1996 Appropriation.....	\$ 300,000,000
1997 Request.....	<u>300,000,000</u>

Net change.....	\$---
-----------------	-------

Increases:

	1996 Current	
	<u>Estimate Base</u>	<u>Change from Base</u>

Program:

1. State grants.....	\$966,795,626	+\$454,274
----------------------	---------------	------------

Total increases.....		+\$454,274
----------------------	--	------------

Decreases:

1. Payment of prior year		
debt.....	\$454,374	-\$454,374

Total decreases.....		-\$454,374
----------------------	--	------------

Net Change.....		---
-----------------	--	-----

Budget Authority by Activity

	<u>1995 Actual</u>	<u>1996 Policy</u> ¹	<u>1997 Estimate</u>
Training and Technical Assistance.	\$250,000	\$250,000	\$250,000
Program Grants....	1,286,452,479	967,250,000	967,250,000
Leveraging Incentive Fund.....	32,500,000	32,500,000	32,500,000
Emergency Fund.....	(600,000,000) ²	(300,000,000)	(300,000,000)
Emergency Supplemental	100,000,000	---	---
Amount available for obligation in FY 1998.	---	---	(1,000,000,000)
Total Budget Authority	\$1,419,202,479	\$1,000,000,000	1,000,000,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

² As reflected in the FY 1995 Supplemental, P.L. 104-19, \$100,000,000 of the \$600,000,000 in the Emergency Fund was made available to States who experienced record heat in the summer of 1995.

Budget Authority by Object

	1996 <u>Policy</u> ¹	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Other Services	\$250,000	\$250,000	---
Grants, Subsidies, and Contri- butions.....	999,750,000	999,750,000	---
Total, Budget Authority by Object.....	\$1,000,000,000	\$1,000,000,000	---
Advance Requested for FY 1998		(\$1,000,000,000)	

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

Authorizing Legislation

	1996 Amount Authorized	1996 Policy ¹	1997 Amount Authorized	1997 Budget Request
<u>Home Energy Assistance Activity:</u>				
1. Sec. 2602 (b) of the Low Income Energy Assistance Act of 1981, as amended.	\$2 billion	967,250,000	\$ 2 billion	967,250,000
2. Leveraging Incentive Fund, Section 2602 (d) of the Low-Income Home Energy Assistance Act of 1981, as amended...	50,000,000	32,500,000	50,000,000	32,500,000
3. Energy Emergency Contingency Fund,				

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

Section 2602(e)
of the Low-Income
Home Energy
Assistance Act of
1981, as
amended..

600,000,000 (300,000,000) 600,000,000 (300,000,000)

Appropriation

1,000,000,000 1,000,000,000

Total
Appropriation
against
definite
authori-
zations.

\$2,650,000,000 \$1,000,000,000 \$2,650,000,000 \$1,000,000,000
(300,000,000) (300,000,000)

Low Income Home Energy Assistance Program

APPROPRIATIONS HISTORY TABLE

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1985	1,875,000,000	1,975,000,000	2,140,000,000	2,100,000,000
1986	2,097,765,000	2,097,765,000	2,097,765,000	2,100,000,000
Seq.	---	---	---	-90,204,000
1987	2,097,642,000	Deferred	1,822,265,000	1,825,000,000
1988 ^a /	1,237,000,000	1,822,26,000	1,237,000,000	1,531,840,000
1989	1,187,000,000	1,567,000,000	1,400,000,000	1,383,200,000
1990	1,100,000,000	1,400,000,000	1,278,654,000	1,443,000,000
Supl.	---	---	---	50,000,000
1991	1,050,000,000	Deferred	1,450,000,000	1,415,055,000
Seq.	---	---	---	18,396
Contingency Fund	---	---	---	195,180,000
Seq.	---	---	---	2,537
1992 ^b /	925,000,000	1,000,000,000	1,500,000,000	1,500,000,000
Contingency Fund ^c /	100,000,000	---	---	---
Emergency Alloc. ^d /	---	(600,000,000)	(300,000,000)	(300,000,000)
1993 ^e /	1,065,000,000	891,000,000	1,356,905,000	1,346,030,000
Emergency Alloc.	---	(600,000,000)	(600,000,000)	(595,200,000)
1994 ^f /	1,507,408,000 ^g /	1,437,408,000	1,437,408,000	1,437,408,000

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1994 Emergency Alloc. d/i/	---	---	(600,000,000)	(600,000,000)
1994 Supl.	100,000,000	300,000,000	300,000,000	300,000,000i/
1994 Recs.	---	---	---	-15,640
1995 1,475,000,000h/	1,475,000,000	1,475,000,000	1,475,000,000	1,475,000,000
1995 Resc.	-750,000,000	-250,000,000	-89,592,000	-155,796,000
1995 Adm. Red.	---	---	---	-1,521
1995 Emergency Alloc.	---	(600,000,000)	(600,000,000)	(600,000,000)k/
1995 Supl.	100,000,000	100,000,000	100,000,000	100,000,000
1996 Emerg. Alloc.	---	---	---	(300,000,000)
1996 1,319,204,000 appropriated in FY 1995 for obligation in FY 1996.				1,319,204,000
1996 Resc	---	---	---	-319,204,000
1996 Action		-1,000,000,000	100,000,000l/	1,000,000,000m/
1997	1,000,000,000			
1997 Emrg. Fund	(300,000,000)			
1998 Adv. Fund.	1,000,000,000			

a/ All of the amounts shown, beginning with FY 1988, exclude Federal Administration which was consolidated into the Family Support Administration's Program Administration budget activity.

b/ Of the \$1.5 billion appropriated, \$1,094,393,000 was available for obligation 10/1/91 and \$405,607,000 was not available until 9/30/92.

c/ The request included emergency funding of \$100,000,000 to be available for obligation after January 15, 1992, providing certain provisions were met.

d/ Available only upon submission of a formal budget request designating the need for funds as an emergency under the Budget Enforcement Act.

e/ Of the \$1,065 million requested, \$798,750,000 was requested as delayed obligations, not available for obligation until September 30, 1993. Of the amount appropriated, \$682,218,240 was not available for obligation until September 30, 1993.

f/ Appropriated in the FY 1993 Appropriations Act, available for obligation October 1, 1993, of which \$141,950,240 was available for reimbursement of costs incurred in FY 1993.

g/ Advance appropriation requested: \$70,000,000 to become available July 1, 1994, and \$1,404,780,000 to become available for obligation October 1, 1994 through June 30, 1995.

h/ Of the amount requested for FY 1995, it was requested that \$745,000,000 be made available in the period October 1, 1995 through September 30, 1996, with the balance of \$730,000,000 available October 1, 1994 through September 30, 1995. Congress did not approve this request.

i/ As reflected in the FY 1994 Emergency Earthquake Supplemental, up to \$300,000,000 was made available to States who experienced record cold temperatures in January of 1994.

j/ FY 1995 appropriation language requested that the balance of these funds remain available until expended. Congress did not approve this request.

k/ FY 1996 appropriation language proposed that these funds remain available until expended. Congress has not approved that request.

l/ Senate Committee Mark.

m/ An amount of \$1,319,204,000 was made available in FY 1995 as an advance appropriation for obligation in FY 1996. An amount of

\$319,204,000 was later rescinded. As part of Congressional action on the FY 1996 budget, the House proposed a further rescission of the entire \$1,000,000,000, and the Senate proposed a further rescission of \$100,000,000. At the time this budget was prepared, an FY 1996 appropriation for this account had not been enacted. The amounts included for FY 1996 are based on levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

Justification

Low Income Home Energy Assistance Program

	1996 <u>Policy</u> ¹	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Program Grants	\$967,250,000	\$967,250,000	\$---
Leveraging Incentive Grants	32,500,000	32,500,000	---
Subtotal	999,750,000	999,750,000	---
Emergency Fund	(300,000,000) ²	(300,000,000)	
Training and Technical Assistance	250,000	250,000	---
Total, Budget Authority	\$1,000,000,000	\$1,000,000,000	\$---

General Statement

The Low Income Home Energy Assistance Program (LIHEAP) provides assistance to low income households in meeting the costs of home energy: heating and cooling their homes. The budget request takes into account the requirement to reduce the Federal deficit, as well as to maintain assistance in a critical health and safety area. Approximately twenty-one percent of LIHEAP recipients are "working poor" or elderly, who do not receive any other public assistance through AFDC, food stamps, SSI, or subsidized housing.

Legislation enacted in 1994 made it easier for States to use LIHEAP funds more effectively to target assistance to households

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

² Included as part of the ninth Continuing Resolution.

with high energy burdens or need and authorized States to use a portion of their funds to assist households in reducing their need for home energy. A number of States have already completed, or are in the process of, examining their programs to target resources more effectively.

A leveraging incentive fund has been successful in encouraging States to develop increased non-Federal energy assistance resources to be used in conjunction with LIHEAP funds. Beginning in FY 1996, a new Residential Energy Assistance Challenge Grant program will become a component of the leveraging incentive fund. It will assist States in developing and operating programs to help LIHEAP-eligible households reduce their energy vulnerability.

This program is not intended to meet the entire home energy costs of low-income households. Rather, it is intended to supplement assistance available through such programs as AFDC, SSI, and housing subsidies, as well as the households' own resources and State resources. Appropriations for this program were increased in the early 1980's to offset continually escalating energy costs. Energy costs declined in the mid-to-late 1980's, and have been relatively stable ever since.

Under the LIHEAP statute, funding is to be appropriated one year in advance in order for States to have adequate time for planning. Advanced funding was implemented in 1994.

The President's appropriation request of \$1,000,000,000 for this account represents current law requirements. No proposed law amounts are included.

Low Income Home Energy Assistance Program

Authorizing Legislation - Section 2602(b) of the Low Income Home Energy Assistance Act of 1981, as amended.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy¹</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$1,319,202,479	\$1,000,000,000	\$1,000,000,000	\$---

Advance

Appropriation for FY 1998: \$1,000,000,000

1997 Authorization.....\$2,000,000,000
 1998 Authorization.....\$2,000,000,000

Purpose and Method of Operations

The Low Income Home Energy Assistance Program provides funds to aid low income households through payments to eligible households and energy suppliers. Funds are provided through block grants to States, Indian Tribes and tribal organizations, Puerto Rico and five other territories for their use in programs tailored to meet the unique requirements of their jurisdictions. This program assists eligible households in meeting the costs of home energy, defined by the statute to include sources of residential heating and cooling.

In FY 1996 and FY 1997, the statute allows States to make payments to, or on behalf of, eligible households meeting the following criteria:

- o One or more individuals receive either Aid to Families with Dependent Children, Supplemental Security Income payments, Food Stamps, or certain needs-based veterans benefits; or
- o The household's total income does not exceed the higher of 150 percent of the poverty level or 60 percent of the State median income level. States may establish lower income eligibility criteria, but they may not exclude households with incomes below 110 percent of the poverty level solely

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

on the basis of income. States may give priority to households with the highest home energy costs or need in relation to income.

States are allowed flexibility in determining payment levels and types of payments, including unrestricted cash payments, payments to vendors on behalf of eligible households, or energy vouchers. Beginning with FY 1994, grantees were no longer permitted to transfer funds to other block grants. Up to ten percent of the funds payable to a State may be used to pay State planning and administrative costs. A grantee may hold up to ten percent of the funds payable to it for obligation in the subsequent year.

Beginning in FY 1992, a portion of the appropriation may be made available to reward those grantees that leverage their Federal LIHEAP dollars so that they cover more services or benefits. Continuing to earmark a portion of program grant appropriations for leveraging purposes is recommended. In FY 1995, \$30,000,000 was made available for this purpose; \$32,500,000 in FY 1996. This request includes \$32,500,000 for FY 1997.

Recent funding levels have been:

FY 1992.....	1,500,000,000
FY 1993.....	1,346,030,000
FY 1994 (advance appropriation-FY 1993)	1,437,392,760 ¹
FY 1994 Emergency Supplemental.....	300,000,000
FY 1995 (advance appropriation-FY 1994)	1,319,202,479 ²
FY 1995 Supplemental.....	100,000,000
FY 1996.....	1,000,000,000 ³

Rationale for the Budget Request

In the FY 1995 appropriations bill, Congress provided an advance appropriation of \$1,319,204,000 for FY 1996. Of that amount, \$319,204,000 was rescinded, leaving a balance available of \$1,000,000,000, and that is the amount currently available for FY 1996. The amount of \$1,000,000,000 requested for FY 1997 is

¹ The FY 1994 advance appropriation (appropriated in FY 1993 for obligation in FY 1994) of \$1,407,408,000 was reduced by an administrative cost rescission of \$15,640.

² The FY 1995 advance appropriation (appropriated in FY 1994 for obligation in FY 1995) of \$1,475,000,000 was reduced by two rescissions: one of \$155,786,000, and an administrative cost rescission of \$1,521.

³ The FY 1996 advance appropriation (appropriated in FY 1995 for obligation in FY 1996) of \$1,319,204,000 was reduced by a rescission of \$319,204,000.

the same as the amount made available in FY 1996. Advance funding of \$1,000,000,000 is requested for FY 1998.

Low Income Home Energy Assistance ProgramEmergency Funds

Authorizing Legislation - Section 2602(e) and 2604(g) of the Low Income Home Energy Assistance Act of 1981, as amended.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy¹</u>	<u>1997</u> <u>Estimate</u>	Increase or <u>Decrease</u>
(\$600,000,000)	(\$300,000,000)	(\$300,000,000)	---
\$100,000,000			

1997 Authorization - \$600,000,000

Purpose and Method of Operation

A contingency fund was made available initially in January 1991, because the national average retail price of home heating oil in December 1990 exceeded by more than 20 percent the average of the national average retail price for home heating oil for the corresponding month for 1986, 1987, 1988, and 1989. These were the criteria included in the appropriation act. Funds were allotted to the fifty States and the District of Columbia in proportion to the consumption of home heating oil, liquid petroleum gas, and kerosene by low-income households.

The Labor/HHS Education Appropriation Act for FY 1992 contained a emergency fund in the amount of \$300,000,000; the FY 1993 Appropriation Act contained a emergency fund in the amount of \$595,200,000; and the FY 1994 and FY 1995 Appropriation Acts contained emergency funds in the amount of \$600,000,000. In each of these years the funds were to be made available only if requested by the President and designated as an emergency under the Budget Enforcement Act. None of the contingency funds was requested by the President in either FY 1992 or FY 1993. Through FY 1994, contingency funds were included on a one-year basis in appropriation acts because there was no authorizing language. In FY 1994, the 1994 Emergency Earthquake Supplemental provided that up to \$300,000,000 be made available to States who experienced record cold temperatures in January of 1994. In FY 1995, \$100,000,000 was made available to States which experienced unusually hot temperatures during the summer of 1995.

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

In the 1994 amendments to the authorizing statute, language was added to provide a permanent authorization for the emergency fund and to permit targeting of grants to meet emergency needs.

Recent appropriations for this program have been:

FY 1992.....	(\$300,000,000)
FY 1993.....	(\$595,200,000)
FY 1994.....	(\$600,000,000) ¹
FY 1995.....	(\$600,000,000) ²
FY 1996.....	(\$300,000,000)

Rationale for the Budget Request

For FY 1997, \$300,000,000 is requested for emergency purposes, to become available only if the President requests them as part of an emergency designated under the Budget Enforcement Act. This is the same level as was provided under the same conditions in FY 1996.

Of the \$300,000,000 made available in FY 1995, the President released \$100,000,000 to assist low income households adversely affected by the severe heat during the summer of 1995.

¹ The FY 1994 Emergency Earthquake Supplemental provided \$300,000,000 to be made available to States who experienced record cold temperatures in January of 1994. These funds were distributed in February 1994.

² Under the terms of the 1994 amendments to the statute, supplemental funds in the amount of \$100,000,000 were made available in July 1995 to States who experienced severe heat during the summer of 1995.

Low Income Home Energy Assistance Program (LIHEAP)

Program Data:

	<u>FY 1995 Actual</u>	<u>FY 1996 Policy ¹</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	1,288,137,862	966,795,626	967,250,000
Discretionary ²	130,000,000	32,500,000	32,500,000
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	250,000	250,000	250,000
Evaluation	---	---	---
Program Support	---	---	---
Other ³	<u>814,517</u>	<u>454,374</u>	<u>---</u>
Total Program	\$1,419,202,379	\$1,000,000,000	\$1,000,000,000
Number of Applicants	180	177	180
Number of Grants	286	262	270
New Starts:			
#	106	85	90
\$	130,000,000	32,500,000	32,500,000
Continuations:			
#	180	177	180
\$	1,288,137,862	966,795,626	967,250,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

² Includes \$100,000,000 in supplemental funds in FY 1995 and leveraging funds of \$30,000,000 in FY 1995; \$32,500,000 in FY 1996 and FY 1997.

³ Payment of prior year debt, per section 1405 of P.L. 101-510.

Contracts:

\$⁶
250,000⁶
250,000⁶
250,000

STATE TABLES

LOW INCOME HOME ENERGY ASSISTANCE

State	1995 Actual	1996 Policy	1997 Estimate
Alabama	\$11,063,344	8,303,617	\$ 8,307,519
Alaska	7,061,980	5,300,385	5,302,876
Arizona	5,350,365	4,015,728	4,017,615
Arkansas	8,441,854	6,336,052	6,339,030
California	59,351,618	44,546,486	44,567,422
Colorado	20,694,060	15,531,971	15,539,271
Connecticut	26,996,131	20,262,005	20,271,527
Delaware	3,583,217	2,689,391	2,690,658
Dist. of Columbia	4,192,544	3,146,723	3,148,202
Florida	17,505,513	13,138,801	13,144,976
Georgia	13,840,792	10,388,237	10,393,119
Hawaii	1,393,844	1,046,153	1,046,644
Idaho	8,072,062	6,058,504	6,061,351
Illinois	74,720,629	56,081,730	56,108,088
Indiana	33,831,402	25,392,232	25,404,166
Iowa	23,976,768	17,995,815	18,004,273
Kansas	11,011,207	8,264,486	8,268,370
Kentucky	17,605,747	13,214,032	13,220,242
Louisiana	11,310,571	8,489,174	8,493,163
Maine	17,489,189	13,126,549	13,132,718
Maryland	20,670,596	15,514,361	15,521,652
Massachusetts	54,001,202	40,530,720	40,549,768
Michigan	70,940,688	53,244,688	53,269,711
Minnesota	51,108,752	38,359,785	38,377,813
Mississippi	9,485,099	7,119,062	7,122,407
Missouri	29,846,336	22,401,233	22,411,761
Montana	9,468,016	7,106,240	7,109,580
Nebraska	11,857,432	8,899,621	8,903,804
Nevada	2,512,907	1,886,068	1,886,954
New Hampshire	10,221,326	7,671,638	7,675,244

LOW INCOME HOME ENERGY ASSISTANCE (continued)

State	1995 Actual	1996 Policy	1997 Estimate
New Jersey	50,131,717	37,626,469	37,644,153
New Mexico	6,698,285	5,027,413	5,029,776
New York	163,687,641	122,856,114	122,913,855
North Carolina	24,394,426	18,309,289	18,317,894
North Dakota	10,285,130	7,719,527	7,723,155
Ohio	66,101,564	49,612,673	49,635,990
Oklahoma	10,169,485	7,632,729	7,636,317
Oregon	16,038,771	12,037,934	12,043,592
Pennsylvania	87,924,411	65,991,859	66,022,873
Rhode Island	8,888,906	6,671,588	6,674,723
South Carolina	8,786,550	6,594,764	6,597,863
South Dakota	8,353,327	6,269,607	6,272,554
Tennessee	17,834,245	13,385,531	13,391,822
Texas	29,123,333	21,858,581	21,868,854
Utah	9,616,579	7,217,744	7,221,136
Vermont	7,661,248	5,750,166	5,752,869
Virginia	25,179,097	18,898,226	18,907,108
Washington	26,381,569	19,800,744	19,810,050
West Virginia	11,651,060	8,744,728	8,748,838
Wisconsin	46,005,216	34,529,315	34,545,543
Wyoming	3,850,267	2,889,826	2,891,184
American Samoa	28,632	21,490	21,559
Guam	62,774	47,115	47,257
Mariana Islands	21,803	16,364	16,419
Marshall Islands	0	0	0
Micronesia	0	0	0
Palau	13,627	10,220	6,814
Puerto Rico	1,558,270	1,169,571	1,173,190
Virgin Islands	59,359	44,552	44,688
Leveraging	30,000,000	32,500,000	32,500,000
Discretionary	1,089,996	704,374	250,000
Total, Budget Authority	\$1,319,202,479	\$1,000,000,000	\$1,000,000,000

LOW INCOME HOME ENERGY ASSISTANCE
DISASTER RELIEF

State	1995 Actual	1996 Policy	1997 Estimate
Alabama	0		
Alaska	0		
Arizona	0		
Arkansas	0		
California	0		
Colorado	0		
Connecticut	1,015,148		
Delaware	0		
D.C.	0		
Florida	0		
Georgia	0		
Hawaii	0		
Idaho	0		
Illinois	15,724,820		
Indiana	5,736,187		
Iowa	4,606,870		
Kansas	0		
Kentucky	5,390,489		
Louisiana	0		
Maine	0		
Maryland	0		
Massachusetts	2,311,162		
Michigan	10,805,793		
Minnesota	5,043,282		
Mississippi	0		
Missouri	7,183,716		
Montana	0		
Nebraska	2,714,978		
Nevada	0		
New Hampshire	313,517		

LOW INCOME HOME ENERGY ASSISTANCE
DISASTER RELIEF (continued)

State	1995 Actual	1996 Policy	1997 Estimate
New Jersey	0		
New Mexico	0		
New York	11,543,960		
North Carolina	0		
North Dakota	582,519		
Ohio	10,244,876		
Oklahoma	0		
Oregon	0		
Pennsylvania	7,405,892		
Rhode Island	452,019		
South Carolina	0		
South Dakota	965,762		
Tennessee	0		
Texas	0		
Utah	0		
Vermont	246,448		
Virginia	0		
Washington	0		
West Virginia	0		
Wisconsin	7,712,562		
Wyoming	0		
Total, Budget Authority	\$100,000,000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Children and Families Services Programs

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation Language and explanation of language changes.	H-3
Amounts Available for Obligation	H-4
Summary of Changes	H-6
Budget Authority by Activity	H-9
Budget Authority by Object	H-12
Administrative Costs	H-14
Significant Items in House and Senate Appropriations Committee Reports.	H-16
Authorizing Legislation.	H-21
Appropriation History Table.	H-34
Justification: General Statement.	H-36
Narrative	
1. Head Start	H-40
2. Community-Based Resource Centers.	H-47
3. Temporary Child Care and Crisis Nurseries	H-50
4. Family Violence	H-53
5. Comprehensive Runaway and Homeless Youth	H-57
6. Runaway and Homeless Youth Program	H-60
7. Transitional Living Program for Homeless Youth	H-63
8. Drug Education and Prevention Program for Homeless Youth.	H-66
9. Teenage Pregnancy Prevention Initiative	H-68
10. Child Abuse State Grants.	H-71
11. Child Welfare Services.	H-74
12. Child Welfare Innovative Programs	H-77
13. Child Welfare Training.	H-80
14. Child Welfare Research and Demonstration.	H-83
15. Adoption Opportunities.	H-86
16. Child Abuse Discretionary Activities.	H-89
17. Abandoned Infants Assistance Program.	H-92

18.	Developmental Disabilities: State Grants. . . .	H-94
19.	Developmental Disabilities Protection and Advocacy	H-98
20.	Developmental Disabilities Projects of National Significance	H-101
21.	Developmental Disabilities University- Affiliated Programs	H-104
22.	Native American Programs.	H-107
23.	Social Services Research and Demonstration. . .	H-112
24.	Community Services Block Grants	H-117
25.	Emergency Community Services for the Homeless .	H-120
26.	Community Services Discretionary Activities . .	H-123
27.	Community Demonstration Partnership	H-128
28.	Community Food and Nutrition	H-130
29.	Federal Administration.	H-133
State Tables.		H-145

CHILDREN AND FAMILY SERVICES PROGRAM

For carrying out, except as otherwise provided, the Runaway and Homeless Youth Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Head Start Act, the Child Abuse Prevention and Treatment Act, chapters 1 and 2 of subtitle B of title III of the Anti-Drug Abuse Act of 1988, the Family Violence Prevention and Services Act, the Native American Programs Act of 1974, title II of Public Law 95-266 (adoption opportunities), the Abandoned Infants Assistance Act of 1988, and part B (1) of title IV and section 1110 of the Social Security Act; for making payments under the Community Services Block Grant Act; and for necessary administrative expenses to carry out said Acts and titles I, IV, X, XI, XIV, XVI, and XX of the Social Security Act, the Act of July 5, 1960 (24 U.S.C. ch. 9), the Omnibus Budget Reconciliation Act of 1981, title IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, Public Law 100-77, sections 30401, 40211, 40241, and title III of Public Law 103-322, and section 126 and titles IV and V of Public Law 100-485, \$5,251,328,000, of which \$30,000,000 for the Teen Pregnancy Prevention Program under section 1110 of the Social Security Act shall remain available until expended.

Note. -A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 Administration for Children and Families
 Children and Family Services Programs

Amounts Available for Obligation

	1995 <u>Enacted</u>	1996 a/ <u>Policy</u>	1997 <u>Estimate</u>
Appropriation:			
Annual.....	\$4,206,200,000	\$4,289,219,000	4,511,700,000
Head Start Investment initiative.....	209,000,000	97,000,000	350,028,000
Subtotal, adjusted appropriation..	\$4,415,200,000	\$4,386,219,000	4,861,728,000
Comparative transfer from Community Services Program.....	457,633,000	428,564,000	389,600,000
Comparative transfer to Child Care & Development Block Grant...	-14,183,000	---	---
Comparative transfer to the Violent Crime Reduction Account	-10,420,000	---	---
Subtotal, adjusted			
budget authority	<u>\$4,848,230,000</u>	<u>\$4,814,783,000</u>	<u>\$5,251,328,000</u>

Offsetting collections from:			
Federal funds.	28,000,000	22,000,000	22,000,000
Unobligated balance, start of year	9,000,000	13,000,000	13,000,000
Unobligated balance, end of year...	-13,000,000	-13,000,000	-13,000,000
Unobligated balance, lapsing	<u>-4,000,000</u>	<u>---</u>	<u>---</u>
Total Obligations...	\$4,868,230,000	\$4,838,300,000	\$5,273,328,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

SUMMARY OF CHANGES

FY 1996 Policy.	\$4,816,300,000
FY 1997 Estimate.	<u>\$5,251,328,000</u>
Net Change.	\$435,028,000

	1996	
	<u>Policy</u>	<u>Change from Base</u>

Increases:A. Built-in:

1. Annualization of January 1996 pay raise, within grade increases, and Jan. 1997 pay raise.....	\$97,168,000	+ \$4,629,000
2. Related Personnel benefits.....	17,405,000	+710,000
3. Benefits for former personnel.....	500,000	+11,000
4. Insurance Claims, Indemnities.....	110,000	+2,000
5. Transportation of things	67,000	+1,000
6. Rental Payments to GSA..	13,436,000	+295,000
7. Communications/Utilities/ Misc.....	2,247,000	+49,000
Subtotal Increases....		+\$ 5,697,000

B. PROGRAM:

Increases:

1. Investment in the Head Start Program.....	3,631,000,000	+ 350,028,000
2. Consolidation of Runaway & Homeless Youth Program...	---	+68,572,000
3. Increase in Community Based Resource Centers to include Family Support Centers and Temporary Child Care and Crisis Nurseries.....	---	+50,569,000

4. Consolidation of Child Welfare Research, Child Welfare Training, Adoption Opportunities and Child Abuse Discretionary into the Child Welfare Innovative Programs	---	+39,178,000
5. Creation of Teen Pregnancy Prevention Initiative...	---	+30,000,000
6. Increase in Abandoned Infants	12,406,000	+2,000,000
7. Increase in Developmental Disabilities' Special Projects and University Affiliated Projects.....	18,410,000	+6,284,000
8. Increase in Native Americans Programs.....	35,000,000	+3,383,000
9. Funds for Social Services Research and Demonstration	---	+10,000,000
10. Operations & Maintenance of Equipment.....	1,136,000	+25,000
11. Increase of goods and services from government accounts.	10,060,000	+224,000
12. Travel for Technical Assistance and Monitoring.....	1,721,000	+1,269,000
13. Advisory and Assistance..	35,000	+1,000
14. Other Services (includes ADP).....	5,043,000	+1,126,000
15. Supplies and materials...	638,000	+14,000
16. Equipment/Consolidation..	459,000	+998,000
17. Printing and Reproduction	901,000	+20,000
18. Increase in advisory and assistance		
Subtotal Program		+563,663,000
Increases		
Total INCREASES.....		+569,360,000

Decreases:

1. Consolidation of current Runaway and Homeless Youth Program in order to consolidate related programs....	43,500,000	-43,500,000
2. Consolidation of current Transitional Living for Homeless Youth Program into consolidated related programs	13,648,000	-13,648,000
3. Redirection of Child Abuse Discretionary Activities, Child Welfare Training, & Adoption Opportunities to Child Welfare Innovative Programs.....	28,385,000	-28,385,000
4. Redirection of Temporary Child Care and Crisis Nurseries to the Community Based Resource Centers..	9,835,000	-9,835,000
5. Elimination of Community Services discretionary programs.....	26,964,000	-26,964,000
6. Elimination of National Youth Sports.....	12,000,000	-12,000,000
Subtotal, Program Decreases		-\$134,332,000
Total		<u>-\$134,332,000</u>
Net Change.....		+\$435,028,000

Budget Authority by Activity

	1995 <u>Enacted</u>	1996 a/ <u>Policy</u>	1997 <u>Estimate</u>
1. Head Start.....	3,534,129,000	3,631,000,000	3,981,028,000
2. Community-Based Resource Centers	50,569,000	9,835,000	50,569,000
3. Temporary Child Care and Crisis Nurseries.....	[11,835,000]	[9,835,000]	1/
4. Family Support Centers	[7,371,000]	---	1/
5. Family Violence.	32,619,000	32,619,000	32,619,000
6. Comprehensive Runaway and Homeless Youth	68,572,000	57,149,000	68,572,000
7. Runaway and Homeless Youth Program.....	[40,458,000]	[43,500,000]	---
8. Transitional Living Program for Homeless Youth.....	[13,649,000]	[13,949,000]	---
9. Drug Education and Prevention Program for Homeless Youth	[14,466,000]	---	---
10. Teen Pregnancy Prevention Initiative	---	---	30,000,000
11. Child Abuse State Grants....	22,854,000	22,854,000	22,854,000
12. Child Welfare... Services.....	291,989,000	291,989,000	291,989,000
13. Child Welfare Innovative Programs	39,178,000	28,385,000	39,178,000
14. Child Welfare Training.....	[4,398,000]	[2,000,000]	2/
15. Child Welfare Research and Demonstration...	[6,395,000]	---	2/
16. Adoption Opportunities...	[13,000,000]	[11,000,000]	2/
17. Child Abuse Discretionary Activities.....	[15,385,000]	[15,385,000]	2/
18. Advisory Board on Child Abuse and Neglect.....	288,000	---	---
19. Abandoned Infants Assistance Program.....	14,406,000	12,406,000	14,406,000

20. Developmental Disabilities:			
State Grants....	70,438,000	70,438,000	70,438,000
21. Developmental Disabilities Protection and Advocacy.....	26,718,000	26,718,000	26,718,000
22. Developmental Disabilities Projects of National Significance....	5,715,000	3,323,000	5,715,000
23. Developmental Disabilities University-Affiliated Programs	18,979,000	15,087,000	18,979,000
24. Native American Programs.....	38,382,000	35,000,000	38,382,000
25. Social Services Research and Demonstration...	14,961,000	---	10,000,000
26. Community Services Block Grants....	389,600,000	389,600,000	389,600,000
27. Community Services for the Homeless	19,752,000	---	---
28. Community Services Discretionary Activities.....	26,964,000	26,964,000	---
29. National Youth Sport.....	12,000,000	12,000,000	---
30. Community Demonstration Partnership.....	641,000	---	---
31. Community Food and Nutrition...	8,676,000	---	---
32. Federal Administration..	162,299,000	150,933,000	160,279,000
Total, Budget Authority...	\$4,849,730,000	\$4,816,300,000	\$5,251,328,000
Total, FTE.....	(1,803)	(1803)	(1803)
Investment Initiative.....	[209,000,000]	[97,000,000]	[350,028,000]

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1/ The Temporary Child Care and Crisis Nurseries and the Family Support Centers were consolidated into the Community-Based Resource Centers.

2/ The Child Welfare Research, Child Welfare Training, Adoption Opportunities and Child Abuse Discretionary programs were consolidated into the Child Welfare Innovative Programs.

Budget Authority by Object

	1996 a/ <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Full-time equivalent employment ceiling.	1,803	1,803	---
Full-time equivalent of overtime and holiday hours	2	3	+1
Personnel compensation:			
Full-time permanent	\$95,748,000	\$99,790,000	+\$4,042,000
Other than full-time permanent.....	1,370,000	1,427,000	+57,000
Other personnel compensation.....	<u>50,000</u>	<u>580,000</u>	<u>530,000</u>
- Subtotal personnel compensation.....	\$97,168,000	\$101,797,000	+4,629,000
Personnel benefits..	17,405,000	18,115,000	+710,000
- Benefits for former personnel.....	500,000	511,000	+11,000
Travel and transportation of persons.....	2,357,000	3,626,000	+1,269,000
Transportation of things.....	67,000	68,000	+1,000
Rental payments to GSA.....	13,436,000	13,731,000	+295,000
Rental payments to other.....	11,000	11,000	---
Communications, utilities and miscellaneous.....	2,247,000	2,296,000	+49,000
Printing and reproduction.....	1,598,000	1,517,000	-81,000

Consulting Services.	59,430,000	64,618,000	+5,188,000
Other services.....	5,125,000	9,224,000	+4,099,000
Purchases of goods & services for govern- ment accounts.....	19,111,000	20,284,000	+1,173,000
Supplies and materials	638,000	652,000	+14,000
Equipment.....	459,000	1,457,000	+998,000
Grants, Subsidies and Contributions...	4,595,304,000	5,011,949,000	+416,645,000
Indemnities.....	<u>110,000</u>	<u>112,000</u>	<u>+2,000</u>
TOTAL BUDGET			
AUTHORITY			
BY OBJECT.....	\$4,816,300,000	\$5,251,328,000	+\$435,028,000
Investment			
Initiative.....	[97,000,000]	[350,028,000]	

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

	Administrative Costs		
	1996 a/ <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Personnel Compensation:			
Full-time			
Permanent (11.1)...	\$95,748,000	\$99,790,000	+\$4,042,000
Other than Full-Time			
Permanent (11.5)...	1,370,000	1,427,000	+57,000
Other Personnel			
Compensation (11.9)	50,000	580,000	+530,000
Total Personnel			
Compensation (11.9)	97,168,000	101,797,000	+4,629,000
Civilian Personnel			
Benefits (12.1)...	17,405,000	18,115,000	+710,000
Benefits to			
Former Personnel (13.0)	500,000	511,000	+11,000
Travel (21.0).....	2,357,000	3,626,000	+1,269,000
Transportation			
of Things (22.0)...	67,000	68,000	+1,000
Rental Payments to			
Others (23.2)	11,000	11,000	---
Communications, Utilities			
& Miscellaneous			
charges (23.3)....	2,247,000	2,296,000	+49,000
Printing &			
Reproduction (24.0)	1,598,000	1,517,000	-81,000
Consulting			
Services (25.1)....	59,430,000	64,618,000	+5,188,000
Other Services (25.2).	5,125,000	9,224,000	+4,099,000
Purchase of Goods &			
Services from			
Govt. accounts (25.3)	19,111,000	20,284,000	1,173,000

Supplies & Materials (26.0).....	638,000	652,000	+14,000
TOTAL.....	\$ 205,657,000	\$ 222,719,000	+\$17,062,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

SIGNIFICANT ITEMS IN HOUSE AND SENATE
APPROPRIATIONS COMMITTEE REPORTS

1995 House Appropriations Committee Report Language

Item

Head Start -- Despite the fact that the program is 30 years old, rigorous evaluation of it has been minimal. The evaluations that do exist suggest that whatever academic and other gains that children make in the program do not last. Further, solid performance standards have been lacking in Head Start, although the Department claims to be making some progress. The Department was unable to tell the Committee during the hearings how many grantees had been terminated from the program over the past 30 years for poor performance.

Action Taken or to be Taken

There is a large body of convincing research on the short and intermediate effects of Head Start that demonstrates that children receive significant benefits from their participation in Head Start. These benefits are reflected through gains that result in children being better prepared for and more successful in school and in their lives generally. It has also been demonstrated that families of Head Start children benefit significantly from their participation in the program.

After reviewing the program and the research the bipartisan Advisory Committee on Head Start Quality and Expansion concluded in December 1993 that, "The evidence is clear that Head Start produces immediate gains for children and families."

A new report by the Packard Foundation's Center for the Future of Children points out the long-term educational and economic gains that make Head Start and other preschool programs for low-income children worth the investment. The Foundation researchers culled the results of nearly 150 studies to conclude that children exposed to early childhood education have higher reading scores, are less likely to be held back a grade or be put into expensive special-education classes and are more likely to graduate from high school. In addition, participants in preschool programs are less likely to go on welfare or become involved with the criminal justice system. (1996)

Following are some of the specific research findings regarding Head Start:

- o Head Start improves intelligence (IQ), academic readiness and achievement, self-esteem, social behavior, and physical health (including better dental and nutritional status, greater immunization rates, and periodic medical screening and treatment). (Zigler and Styfco 1993; McCall, 1993; Datta, 1979; Fosburg et al, 1984; Haskins, 1989; Mann, et al, 1976; McKey, et al, 1985).
- o Several studies show that Head Start helps to improve the lives of parents, including increased parental communication with their children, increased participation in their children's school activities, increased satisfaction with the quality of their own lives, enhanced confidence in their ability to cope and interact in society, improved disciplinary practices with their children, and decreased feelings of depression and anxiety. (Mann, et al, 1976; McKey, et al, 1985; Parker, et al, 1987)
- o Current child development theory is that parent involvement enhances the effects of early childhood programs by producing less subsequent school failure. (Greensburg, 1989; Lazar and Darling, 1982; Lee, et al 1989; Powell, 1986; Seitz, et al 1989; Washington, 1985). In Head Start specifically, research has found that high levels of parental involvement in Head Start are associated with higher levels of subsequent academic achievement. (Kincaid, 1975; Mann, et al, 1976; Monroe and McDonald, 1981; Weld, 1973).
- o Two large longitudinal data bases, the Philadelphia Public Schools and the Montgomery Public Schools, contain evidence of consistent lasting effects for Head Start graduates over low-income children across a number of cohorts. (Hebbeler, 1985; Copple, et. al., 1987).
- o An analysis of Head Start children through the age of 10 identified in the National Longitudinal Study of Youth (NSLY) found positive and persistent effects of participation in Head Start on the test scores of White and Hispanic children. (Currie and Thomas, 1993).
- o Some studies report that Head Start graduates have better high school attendance, are less likely to be retained in grade, and use less special education services. (Bee, 1981; Copple, et al, 1987; Goodstein, 1975; Monroe and McDonald, 1981; Royster and Larson, 1977; Shipman, 1976).

Performance Standards

Since 1975, Head Start has had a solid and comprehensive set of Performance Standards, contained in 45 CFR 1304. These standards have played a key role in the success of the program. They spell out in very clear terms what services each Head Start program is expected to provide to the children and families it serves. Highly praised and much emulated over the years, these standards cover the areas of health, mental health, nutrition, education, social services and parent involvement.

Consistent with the bipartisan Head Start reauthorization legislation enacted in 1994, the Administration is currently revising the Head Start Performance Standards to implement the quality improvement objectives of the legislation and to provide greater flexibility to local programs. This revision has involved extensive consultation with members of the Head Start community, parents, academic experts, and Federal experts. The review also has included examination of requirements developed by States and other child care standard-setting organizations, and has involved experts from these non-federal organizations. It is anticipated that a Notice of Proposed Rulemaking for the revisions of the current Head Start standards will be published for public comment early this spring.

Poor Performing Grantees

Data is not available on poor performing grantees over the last 30 years. However, 25 grantees in the last 2 years have either been terminated or relinquished their grant. The 1994 revisions of the Head Start Act establish a process for dealing with programs not delivering quality services. Poor performing grantees will have a twelve month opportunity to improve. If they are not successful, they will be terminated. This process will ensure that all programs provide quality services.

Item

Head Start facilities -- The Committee encourages the Department to study the feasibility of a Head Start facilities demonstration program that uses federal funds to leverage private investment and works with nonprofit community development finance organizations to manage the process. If the Department determines that the program is feasible, then it should initiate the program. The Department should work with local nonprofit community development finance organizations with expertise and experience in development finance of Head Start and/or other child agencies. The awarding of grants to local organizations would be done through a competitive process.

Action Taken or To Be Taken

ACF is very supportive of efforts to improve the quality of Head Start facilities. In the last few years a number of initiatives have been undertaken to help Head Start grantees improve their ability to find and keep high quality, reasonably priced facilities. ACF appreciates the valuable contributions which can be made by nonprofit community development finance organizations to improve the state of Head Start facilities. ACF will discuss with these organizations ways in which we can work together including a discussion of ways to make facility acquisition and financing easier for Head Start grantees.

1995 Senate Appropriations Committee Report LanguageItem

Head Start -- The Head Start Program has supported a number of innovative and high-quality demonstration programs to serve homeless preschoolers and their families. The Head Start Program has supported a number of innovative and high quality demonstration programs to serve rural and urban homeless children, and substantial startup costs. The Committee recognizes that this demonstration program will expire at the end of 1995, and believes that allowing these slots to expire would squander the Federal investment made in these programs. Therefore, the Committee urges the Department to convert the positions currently be used for the homeless preschool demonstration program to permanent Head Start positions to serve homeless children.

Action Taken or To Be Taken

The Administration for Children and Families has the authority and intends to continue funding the Homeless Demonstration Projects in FY 1996.

Item

Child Welfare --- The Committee directs the Secretary to continue to make child welfare training funds available to schools of social work, with priority given to minority students, and public human service agencies to train students for careers in child welfare.

Action Taken or To Be Taken

The Administration for Children and Families will continue to make child welfare training funds available to the extent that funds are available. We are honoring our priorities and searching for innovative ways to do this in spite of funding cutbacks.

Item

Child Welfare --- The Committee further endorses work directed to policy analysis and outreach programs relating to family care giving and other long-term inter-generational issues. The Committee is especially interested in the development of programs that are self-help in nature and that contribute to containment of social program costs.

Action Taken or To Be Taken

Child Welfare Research and Demonstration funds have been used to support a major research project on relative foster care and the work of the relative care workgroup which is looking at relative care-giving whether or not it is supported by foster care funds. In addition, Child Welfare Research and Demonstration funds were used to support demonstration projects on parent involvement in the planning for and the delivery of child welfare services. These programs are inherently self-help in nature, increasing reliance on family care-giving and decreasing the need for government intervention.

Authorizing Legislation

ACF ServicePrograms:

	1996 Amount Authorized	1996h/ Policy	1997 Amount Authorized	1997 Budget Request
1. Head Start [Sec. 639(a) of the Head Start Act, as amended]				
(A) Head Start Transition Grants [Sec. 639 b(1)]	such sums \$35,000,000	3,631,000,000 (35,000,000)	such sums \$35,000,000	3,981,028,000 (35,000,000)
(B) Indian and (not less than Migrant [Sec. the amount 640(a)(2) obligated for (A)] FY 1995)		(240,500,000)	(not less than the amount obligated for FY 1996)	(263,973,000)
(C) Training & Technical Assistance (not less than [Sec. 640(a) 2½ of (2)(C)] appropriation)		(72,620,000)	(not less than 2½ of appropriation)	(79,620,000)
(D) Collaboration grants [Sec. 640(a)(5)(A)]	such sums		such sums	
(E) Infants and Toddlers (4½ of Program appropriation) [Sec. 640(a)(6)]		(145,240,000)	appropriation (4½ of appropriation)	(159,240,000)

	1996 Amount <u>Authorized</u>	1996h/ <u>Policy</u>	1997 Amount <u>Authorized</u>	1997 Budget <u>Request</u>
(F) Research, Demonstration & Evaluation [Sec. 639(b) (2)]	such sums	(5,000,000)	such sums	(5,000,000)
(G) Quality Improvement [Sec. 640 (a) (3) (A)]	(25% of amount exceeding previous year's adjusted appropriation and additional amounts at Secretary's Discretion)		(25% of amount exceeding previous year's adjusted appropriation and additional amounts at Secretary's Discretion)	
(H) Head Start Longitudinal study [Sec. 639(b) of Head Start Act as amended]	(not more than \$3,000,000)		such sums	---
2. Community Based Resource Centers [Sec. 201(i) of the Child Abuse and Treatment Act, as amended]	50,000,000	---	a/	50,569,000
				(62,000,000)

	1996 Amount Authorized	1996h/ Policy	1997 Amount Authorized	1997 Budget Request
3. Temporary Child Care and Crisis Nurseries (Sec. 206 of the Tem- porary Child Care for Children with Disabilities and Crisis Nurseries Act of 1986, as amended)	20,000,000	9,835,000	20,000,000	d/
4. Family Violence Prevention and Services (Sec. 310(a) of the Family Violence Prevention and Services Act, as amended) \$50,000,000		32,619,000	\$60,000,000	32,619,000
5. Comprehensive Runaway and Homeless Youth Program . . .	b/	---	b/	68,572,000
6. Runaway and Homeless Youth, (Sec. 385(a) (1) of the Runaway and Homeless Youth Act, as amended]	b/	43,500,000	b/	b/

	1996 Amount <u>Authorized</u>	1996h/ Policy	1997 Amount <u>Authorized</u>	1997 Budget Request <u>Request</u>
7. Runaway and Homeless Youth Transitional Living Programs [Sec. 385(b) (1) of the Runaway and Homeless Youth Act, as amended]	b/	13,649,000	b/	b/
8. Teen Pregnancy Prevention Initiative [Sec 1110 of Social Security Act, as amended]	---	---	such sums	\$30,000,000
9. Child Abuse State Grants [Sec. 114 of the Child Abuse Prevention and Treatment Act, as amended]	such sums	22,854,000	a/	22,854,000
10. Child Welfare Services [Sec. 420 of the Social Security Act, as amended]	325,000,000	291,989,000	325,000,000	291,989,000

	1996 Amount <u>Authorized</u>	1996h/ Policy	1997 Amount <u>Authorized</u>	1997 Budget Request
11. Child Welfare Innovative Programs [Sec. 114 of the Child Abuse Prevention and Treatment Act, as amended] [Sec. 426 of Social Security Act, as amended]	---	---	e/	39,178,000
12. Child Welfare Training [Sec. 426(a) of the Social Security Act, as amended]	such sums	2,000,000	such sums	e/
13. Child Welfare Research and Demonstration [Sec. 426(a) of the Social Security Act, as amended]	such sums	---	such sums	e/
14. Adoption Opportunities: [Sec. 205(a) of the Child Abuse Preven- tion and Treatment and Adoption Reform Act of 1978, as amended]	such sums	11,000,000	e/	e/

	1996 Amount Authorized	1996h/ Policy	1997 Amount Authorized	1997 Budget Request
(A) Placement of Minority Children [Sec. 205(b)]	such sums	a/	---	e/
(B) Post Legal Adoption Services [Sec. 205(b)]	such sums	a/	---	e/
15. Child Abuse Discretionary Activities [Sec. 114, of the Child Abuse Prevention and Treatment Act, as amended]	such sums	15,385,000	e/	e/
16. Abandoned Infants Assis- tance [Sec. 104(a) of the Abandoned Infants Assis- tance Act, of 1988 as amended]	a/	12,406,000	a/	14,406,000

	1996 Amount <u>Authorized</u>	1996h/ Policy	1997 Amount <u>Authorized</u>	1997 Budget Request
Programs for the				
Developmentally Disabled:				
17. Basic State Grants				
[Sec. 130 of				
Developmental				
Disabilities				
Assistance and				
Bill of Rights				
Acts, as amended]	£/	70,438,000	£/	70,438,000
18. Protection and				
Advocacy [Sec.				
143 of Develop-				
mental Assistance				
and Bill of Rights				
Act, as amended]	£/	26,718,000	£/	26,718,000
19. Developmental				
Disabilities:				
Special Projects				
[Sec. 163 of the				
Development				
Disabilities				
Assistance and				
Bill of Rights				
Act, as amended]	£/	3,323,000	£/	5,715,000
20. University				
Affiliated Pro-				
grams [Sec.				
154(a) of the				

	<u>1996 Amount Authorized</u>	<u>1996th/ Policy</u>	<u>1997 Amount Authorized</u>	<u>1997 Budget Request</u>
Developmental Assistance and Bill of Rights Act, as amended]	f/	15,087,000	f/	18,979,000
21. Programs for Native Americans				
(A) [Sec. 816 (a) of the Native American Pro-grams Act of 1974, as amended]	a/	35,000,000	a/	38,382,000
(B) Native Hawaiian Loan Fund [Sec. 803A (f) (1)]	a/	---	a/	---
22. Social Services Research and Demonstration [Sec. 1110 of the Social Security Act, as amended]	such sums	---	such sums	10,000,000
Community Services:				
23. Community Services Block Grants - [Sec. 672 (b) Community Services Block Grant Act, as amended]	\$525,000,000	\$389,600,000	such sums	\$389,600,000

	1996 Amount <u>Authorized</u>	1996h/ Policy	1997 Amount <u>Authorized</u>	1997 Budget Request
24. Emergency Community Services Homeless Grant - [Sec. 754 of the Stewart B. McKinney Homeless Assistance Act]...	\$50,000,000	---	\$50,000,000	---
25. Discretionary Activities - [Sec. 681 of the Community Services Block Grant Act, as amended]	Not more than 9% of 672(b) appropriation	\$26,964,000	c/	---
26. National Youth Sports Program - [Sec. 682(f) of the Community Services Block Grant Act, as amended]	15,000,000	\$12,000,000	15,000,000	---
27. Demonstration Partnership - [Sec. 408, Human Services Reauthorization Act of 1986, as amended]	\$30,000,000	---	such sums	---

	1996 Amount <u>Authorized</u>	1996h/ Policy	1997 Amount <u>Authorized</u>	1997 Budget Request
28. Community Food and Nutrition Sect. 681A (d), Community Services Block Grant Act, as amended.....	such sums	---	such sums	---
29. Federal				
Administration	Indefinite	150,933,000	Indefinite	160,279,000
Total, Appropriation against definite authorization, ACF	---	\$4,816,300,000	---	\$5,251,328,000
Total, Approp- riation, ACF	---	\$4,816,300,000	---	\$5,251,328,000
a/ Authorizing legislation expired 9/30/95. Reauthorizing legislation will be proposed if necessary.				
b/ Runaway and Homeless Youth Activities are proposed for consolidation; legislation will be proposed.				
c/ Not more than 9 percent of the amounts appropriated under 672 (b) of the Act.				
d/ The FY 1997 request proposes consolidating this program with the Community-Based Resource Centers Program.				
e/ Legislation expired in September 30, 1995. Programs are proposed for consolidation; legislation will be proposed for child welfare innovative programs.				
f/ Authorizing legislation expires 9/30/96. Reauthorizing legislation will be proposed if necessary.				
g/ Legislation expired 9/30/94. FY 1995 and FY 1996 authorizing legislation in FY 1995 and FY 1996 appropriation acts. Reauthorizing legislation will be proposed if necessary.				
h/ Based on levels of the ninth CR, including an incremental policy adjustment.				

	<u>1996</u> Amount <u>Authorized</u>	<u>1996h/</u> <u>Policy</u>	<u>1997</u> Amount <u>Authorized</u>	<u>1997</u> Budget <u>Request</u>
Unfunded Authorizations:				
Head Start Fellowships [Sec. 640(a) (d)] [Sec. 648A(d) (6)]	\$1,000,000	---	\$1,000,000	---
Abandoned Infants Dissemination of Information For Individuals With Special Needs [Sec. 104(b) of the Abandoned Infants Assistance Act of 1988, as amended]	a/	---	a/	---
Native American Environmental Quality [Sec. 816(c) of Native American Programs Act, as amended]	8,000,000	---	k/	---
Native American Studies and Policy Develop- ment [Sec. 816(e)]	such sums	---	such sums	---
Federal Council on Children, Youth and Families [Sec.				

	<u>1996 Amount Authorized</u>	<u>1996h/ Policy</u>	<u>1997 Amount Authorized</u>	<u>1997 Budget Request</u>
918(o) of Claude Pepper Young Americans Act of 1990]	200,000	---	200,000	---
State Coordination and Supportive Services [Sec. 934(a) (1) of Claude Pepper Young Americans Act of 1990]	such sums	---	such sums	---
Family Resources National Centers [Sec. 960(a) of Family Resources Act]	\$2,000,000	---	\$2,000,000	---
Family Resources Evaluation [Sec. 960(b) of Family Resources Act]	such sums	---	such sums	---
Native American Languages Grants [Sec. 816(e) of the Native American Programs Act, as amended]	such sums	---	such sums	---

	1996 Amount <u>Authorized</u>	1996h/ Policy	1997 Amount <u>Authorized</u>	1997 Budget Request
--	-------------------------------------	------------------	-------------------------------------	---------------------------

Demonstration
Projects to Pro-
vide Services to
Youth in Rural
Areas [Sec. 385(c)
of the Runaway and
Homeless Youth Act,
as amended]

1,000,000	---	k/	---
-----------	-----	----	-----

Total, Appro-
priation, ACF

\$12,200,000	---	\$3,200,000	---
--------------	-----	-------------	-----

- a/ Authorizing legislation expired 9/30/95. Reauthorizing legislation will be proposed if necessary.
- b/ Runaway and Homeless Youth Activities are proposed for consolidation; legislation will be proposed.
- c/ Not more than 9 percent of the amounts appropriated under 672 (b) of the Act.
- d/ The FY 1997 request proposes consolidating this program with the Community-Based Resource Centers Program.
- e/ Legislation expired in September 30, 1995. Programs are proposed for consolidation; legislation will be proposed for child welfare innovative programs.
- f/ Authorizing legislation expires 9/30/96. Reauthorizing legislation will be proposed if necessary.
- g/ Legislation expired 9/30/94. FY 1995 and FY 1996 authorizing legislation in FY 1995 and FY 1996 appropriation acts. Reauthorizing legislation will be proposed if necessary.
- h/ Based on levels of the ninth CR, including an incremental policy adjustment.

CHILDREN AND FAMILIES SERVICES PROGRAM
Appropriations History Table

Year	Budget Estimate Congress	House		Senate	
		Allowance		Allowance	Appropriation
1986	---	6,000,0000		16,000,000	11,000,000
1986	1,969,167,000	2,003,722,000		2,009,422,000	2,015,922,000
Seques- tering					
1986	-86,685,200	N/A		N/A	1,929,237,000
Rescission	-24,980,000	---		---	---
1987	1,978,378,000	925,017,000	a/	2,091,018,000	2,097,635,000
1988	2,227,366,000	b/	1,641,456,000	c/	2,571,785,000
1989	2,458,868,000		2,531,808,000		2,573,465,000
1989					2,573,910,000
Supple- mental	---	---		---	---
1990	3,053,275,000	d/	2,757,959,000	c/	2,791,879,000
1990					30,000,000
Sequester	---	---		---	---
1991 e/	3,280,150,000		1,423,217,000	c/	4,748,630,000
Sequester	---	---		---	---
1992 e/	2,666,778,000		2,782,275,000		2,778,201,000
1993 f/	3,644,620,000		3,602,262,000		3,695,384,000
Supple- mental	500,000,000				3,658,390,537
1994	5,051,476,000		4,169,806,000		4,296,796,000
Supple- mental	13,000,000				---
1995	4,878,625,000		4,862,286,000		4,877,550,000
1996	5,234,257,263		4,544,643,000		4,560,652,000
1997	5,251,328,000				4,849,730,000
					g/
					4,816,300,000
					h/

- a/ The House did not provide allowance for Head Start, Dependent Care or Native American Programs, for which there was no reauthorizing legislation.
- b/ This amount reflects the transfer of four programs previously in the Family Social Services account. Amounts in prior years are non-comparable.
- c/ The House deferred acting on any programs requiring the enactment of authorizing legislation.
- d/ This amount reflects the inclusion of Foster Care and Adoption Assistance administrative and training costs. Prior year amounts are non-comparable.
- e/ Excludes appropriations for the Administration on Aging.
- f/ Includes \$270,000,000 transferred from the Department of Education; \$250,000,000 for Head Start and \$20,000,000 for Comprehensive Child Development Centers.
- g/ This amount reflects comparable transfer to Child Care & Development Block Grant (\$14,183,000) and comparable transfer to Violent Crime Reduction Account (\$10,420,000). Transfer from Community Services (\$457,633,000)
- h/ Based on levels of the ninth CR, including an incremental policy adjustment.

Justification
Children and Family Services Programs
(dollars in thousands)

	1996 a/ Policy	1997 Estimate	Increase or Decrease
1. Head Start.....	\$3,631,000	\$3,981,028	+350,028
2. Community-Based Resource Centers	9,835	50,569	+40,734
3. Temporary Child Care and Crisis Nurseries	[9,835]	---	- [9,835]
4. Family Violence	32,619	32,619	---
5. Comprehensive Runaway and Homeless Youth.	57,149	68,572	+11,423
6. Runaway and Homeless Youth	[43,500]	---	- [43,500]
7. Transitional Living for Homeless Youth	[13,649]	---	- [13,649]
8. Teen Pregnancy Prevention Initiative	---	30,000	+30,000
9. Child Abuse State Grants.....	22,854	22,854	---
10. Child Welfare Services.....	291,989	291,989	---
11. Child Welfare Innovative Programs	28,385	39,179	+10,794
12. Child Welfare Training.....	[2,000]	---	- [2,000]
13. Adoption Opportunities.....	[11,000]	---	- [11,000]
14. Child Abuse Discretionary	[15,385]	---	- [15,385]
15. Abandoned Infants..	12,406	14,406	+2,000
16. Developmental Disabilities Basic State Grants.....	70,438	70,438	---
17. Developmental Disabilities Protection and Advocacy.....	26,718	26,718	---
18. Developmental Disabilities Special Projects.....	3,323	5,715	+2,392

	1996 <u>a/</u> Policy	1997 Estimate	Increase or Decrease
19. Developmental Disabilities University Affiliated Programs.....	15,087	18,979	+3,892
20. Native American Programs.....	35,000	38,383	+3,383
21. Social Services Research and Demonstration.....	---	10,000	+10,000
22. Community Services Block Grant	389,600	389,600	---
23. National Youth Sports	12,000	---	-12,000
24. Community Economic Development	23,693	---	-23,693
25. Community Services Rural Community Facilities	3,271	---	-3,271
26. Federal Administration.....	<u>150,933</u>	<u>160,279</u>	<u>+9,346</u>
Total, Budget Authority.....	\$4,816,300	\$5,251,328	+435,028
Investment Initiative..	[97,000]	[350,028]	---
Total, FTE.....	(1,803)	(1,803)	---

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

General Statement

The Fiscal Year 1997 request for Children and Family Services Programs is \$5,251,328,000 and 1,803 FTE, an increase of \$435,028,000 over the 1996 policy level of \$4,816,300,000.

This budget request includes an increase of \$350,028,000 over the FY 1996 policy level for the Head Start program. This increase will be used to maintain and improve quality. This investment will: strengthen quality in all aspects of the program; fund strategic expansion of services; and provide local flexibility to respond to family and community needs. A portion of this proposed increase will be used to increase Head Start enrollment by an estimated 39,600 new children and families, bringing total Head Start enrollment to an estimated 796,500.

The request includes a consolidation of four currently funded discretionary programs: Child Abuse and Neglect discretionary grants, Adoption Opportunities, section 426 Research and Demonstration and section 426 Training into the Child Welfare Innovative programs. The purpose of the Child Welfare Innovative program is to fund programs designed to facilitate the development of new knowledge, policy and programs and to address emerging issues in the field.

The FY 1997 budget request for the Community-Based Resource Centers Program of \$50,569,000 reflects efforts to improve the quality of services to children and families by providing streamlined service delivery through program consolidation. The budget proposes to consolidate, the Temporary Child Care and Crisis Nurseries with the Community-Based Family Resource Program.

This new program will assist each State to develop and implement, or expand and enhance, a comprehensive, statewide system of preventive family resource services through innovative funding mechanisms and collaboration with existing education, vocational rehabilitation, health, mental health, employment and training, child welfare, and other social services agencies within the State. It will result in increased flexibility for each State to provide the mix of preventive services it deems best to meet the needs of its clients.

The requested increase in Federal Administration will improve programmatic and financial monitoring of Federally funded activities; accelerate improvements in ADP systems; improve telecommunications capabilities; and, provide technical assistance, training and evaluation services necessary to support initiatives in child support enforcement and welfare reform.

Effect of Proposed Legislation

The FY 1997 request of \$5,143,578,000 for ACF programs in the Children and Families Services Program appropriation represents current law requirements adjusted by an increase of \$107,750,000 assuming Congressional action on proposed legislation as follows:

Current law appropriation request\$5,143,578,000

Impact of proposed legislative changes:

- o Establish a new authorization for the Consolidated Runaway and Homeless Youth Program..... +\$68,572,000
- o Consolidation of the Runaway and Homeless Youth Program
(under current law would be funded at: \$43,500,000)
- o Consolidation of the Runaway and Homeless Transitional Living Program
(under current law would be funded at: \$13,648,000)
- o Establish a new authorization for the Child Welfare Innovative Program \$39,178,000
- o Consolidation of the Child Welfare Training Program
(under current law would be funded at: \$2,000,000)
- o Consolidation of the Adoption Opportunities Program
(under current law would be funded at: \$11,000,000)

Subtotal, legislative changes +\$107,750,000

Total, appropriation request in the President's budget \$5,251,328,000

Head Start

Authorizing Legislation - Section 639 of the Head Start Act, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$3,534,129,000	\$3,631,000,000	\$3,981,028,000	+\$350,028,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Such sums.

Purpose and Method of Operations:

Head Start provides grants to local, public and private non-profit agencies for comprehensive child development services to children and families. Intended primarily for preschoolers from low-income families, the program fosters the development of children and enables them to deal more effectively with both their present environment and later responsibilities in school and community life. Head Start programs emphasize cognitive and language development and socio-emotional development to enable each child to develop and function at his or her highest potential. Head Start children also receive comprehensive health services, including immunizations, physical and dental exams and treatment, and hot meals to help meet daily nutritional requirements. The Head Start program also emphasizes significant involvement of parents in their child's development. At least ten percent of the enrollment opportunities in each program must be made available to children with disabilities.

Grantees must contribute 20 percent of the total cost of the program from non-Federal funds. No more than 15 percent of total costs may be for program administration.

The Head Start Act requires that Head Start programs in each State receive minimum funding levels based on each State's relative number of poor children, ages 0-5, and its relative number of children, ages 0-18, in families receiving AFDC benefits, as compared to all other States.

Most Head Start programs now provide center-based services to children for three and one half or four hours per day, four or five days per week for eight to nine months per year. Grantees have the option of providing full-day and/or full-year services.

In FY 1995, the Early Head Start program was established. This program was created by the President and the Congress in recognition of the mounting evidence that the earliest years,

from birth to three years of age, matter a great deal to children's growth and development. Early Head Start focus is on four cornerstones that are essential to high quality programs: child development, family development, community building and staff development. In FY 1995, the Administration awarded grants under the new Early Head Start program to 68 projects serving children and families in 34 States plus the District of Columbia and Puerto Rico. The programs are located throughout the country in a variety of urban and rural communities. Total annual funding for the 68 Early Head Start grantees is \$47.2 million. An additional \$59 million provides services to additional infant and toddler age children through Comprehensive Child Development Projects and Parent and Child Center programs. Early Head Start funds in FY 1997 will be equal to 4% of the total Head Start budget or \$159.3 million under the President's Request.

In FY 1996, Head Start worked on the development of revised Head Start Performance Standards, as required by the Head Start Act. These standards more clearly articulate the type and scope of services that all Head Start programs are required to provide. FY 1996 also saw extensive work on the development of Head Start Measures, designed to provide a means of assessing the extent to which Head Start programs are having positive impacts on the children and families they serve. Head Start measures are part of the Head Start program's efforts to increase focus on social, educational and health outcomes.

Funding for the Head Start program during the last five years has been as follows:

1992.....	\$2,201,800,000
1993.....	\$3,276,285,604
1994.....	\$3,326,285,000
1995.....	\$3,534,129,000
1996.....	\$3,631,000,000

Rationale for the Budget Request:

The budget request for FY 1997 is \$3,981,028,000, an increase of \$350 million over the FY 1996 policy level. This increase will be used to maintain and improve quality and to increase the number of children and families receiving the benefits of a Head Start experience.

The FY 1997 funding increase will be used to continue the efforts begun three years ago by this Administration to improve and expand the Head Start program. The Administration's vision for Head Start was first articulated in the recommendations of the Final Report of the Advisory Committee on Head Start Quality and Expansion. These recommendations were characterized by three broad principles:

1. We must ensure that every Head Start program can deliver on Head Start's vision by striving for excellence in serving both children and families.

2. We must expand the number of children served and the scope of services provided in a way that is more responsive to the needs of children and families.

3. We must encourage Head Start to forge partnerships with key community and state institutions and programs in early childhood, family support, health, education, and mental health, and we must ensure that these partnerships are constantly renewed and recrafted to fit changes in families, communities, and state and national policies.

FY 1997's proposed funding increase, in accord with these principles, will be used for the following four purposes:

1. To award all grantees a cost-of-living increase \$ 98 million
2. To award grantees quality improvement funds \$ 62 million
3. To improve the Head Start training and technical assistance system \$ 7 million
4. To increase enrollment by almost 40,000 children and families, including 1,200 children and families in the Early Head Start program \$183 million

Maintaining and improving program quality

Cost-of-living and quality funds will be allocated to allow grantees to increase the salaries and fringe benefits of current staff to hire any additional staff needed to assure high program quality, to improve staff training, to improve the condition of Head Start facilities, to acquire necessary supplies and equipment and, where appropriate, to better meet the child care needs of working Head Start families.

Head Start grantees have made significant progress in the last few years in improving program quality by using previous quality improvement increases for hiring additional staff, such as family workers, increasing employee salaries and fringe benefits and improving Head Start facilities. However, there is still a need for further improvement which will help assure all Head Start programs provide services of the highest quality. For example, relatively low wages make it difficult to attract and retain quality staff - the

average teacher, despite recent increases, still earns less than \$17,000 per year. Family workers in many programs still maintain caseloads of two or three times the recommended level of 35 families, thus making it difficult for them to provide families the assistance they need to obtain social services or move toward financial independence. Many facilities are still of marginal quality and many classrooms are ill equipped to meet the needs of Head Start children.

Directly or in cooperation with other organizations that provide child care services, Head Start grantees will also be able to use a portion of their quality increase to meet the full-day child care needs of the families they serve. Many Head Start parents are employed full-time or are in job training. Head Start can play an important role in helping these parents be able to continue to work or participate in training programs. In meeting this need, Head Start programs will be encouraged to strengthen their coordination with other key community organizations that serve children and families to provide a holistic community-wide approach to serving disadvantaged families.

Efforts will continue to assure that every Head Start program maintains an acceptable level of quality and delivers required services to all of the children and families they serve. The performance of Head Start grantees will be closely assessed through an improved monitoring system designed to help programs improve program quality as well as to assure their compliance with required standards. In addition, funds will be targeted to provide training and technical assistance to poorly performing grantees. If grantees are found to have deficiencies which are not corrected within agreed-upon time frames, HHS will terminate their Head Start grant and seek a replacement agency to serve that community.

Increasing Enrollment

According to the most recent data available from the Census Bureau, there are more than two million low-income children living in this country who are either three or four years old. In FY 1996 Head Start will serve an estimated 757,000 children, leaving hundreds of thousands of eligible children and families who do not yet enjoy the benefits of a Head Start experience.

There is an increasing body of evidence which supports the advantages which accrue to disadvantaged children and families who attend Head Start. Studies demonstrate that Head Start programs produce immediate gains for children and families across a diverse range of areas such as cognitive

functioning, academic readiness and achievement, self-esteem, social behavior and physical health. Studies also show that some Head Start children have better high school attendance rates, are less frequently retained in grade and have less need for special education. Head Start has also been shown to help parents improve their parenting skills, increase participation in their children's school activities and enhance their confidence in their abilities to contribute to their communities and, in many cases, to help parents on the road to self-sufficiency. In short, Head Start works and needs to be expanded to reach more of the many Head Start-eligible children and families not currently served by the program.

This investment will continue progress toward the Administration's goal initiated in FY 1994 of providing a high quality, responsive Head Start program to every eligible child and family interested in receiving the benefits of a Head Start experience.

Name of Program: Head Start

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	3,402,946,000	3,498,680,000	3,841,708,000
(O-3 Set Aside)	(106,000,000)	(145,240,000)	(159,240,000)
Research/ Demonstration	5,000,000	5,000,000	5,000,000
Development	--	--	--
Training/Technical Assistance	70,683,000	72,620,000	79,620,000
Children w/Disabilities	3,000,000	3,000,000	3,000,000
Evaluation	7,000,000	7,000,000	7,000,000
Panel Reviews	1,200,000	200,000	200,000
Monitoring	9,300,000	9,500,000	9,500,000
Other 1/	35,000,000	35,000,000	35,000,000
 TOTAL PROGRAM	 3,534,129,000	 3,631,000,000	 3,981,028,000
Number of Applicants	--	--	--
Number of Grants	1,609	1,609	1,629
New Starts:			
#	85	--	30
\$	50,344,000	--	20,000,000
Continuations:			
#	1,524	1,609	1,609
\$	3,431,376,000	3,578,591,000	3,908,619,000
Contracts:			
#	69	69	69
\$	52,409,000	52,409,000	52,409,000

1/ Transition Projects.

Name of Program: Head Start

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Number of Grantees	1,433	1,440	1,455
Children in Head Start Projects	750,696	756,900	796,500
Average ACYF Cost Per Child	4,534	4,622	4,823
Number of Staff	146,750	148,000	155,700
Volunteers	1,235,000	1,250,000	1,315,000
Numbers of Classrooms	42,750	43,000	45,200

Community Based Family Resource Programs

Legislative Authority - Section 201(i) of the Child Abuse Prevention and Treatment Act, as amended.

<u>1995 Enacted</u>	<u>1996 a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$31,363,000	---	\$50,569,000	+\$50,569,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Authorization legislation expired 9/30/95. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operations:

The purpose of the Community Based Family Resource Program is (1) To assist each State in implementing/enhancing a statewide system of family resource services through innovative funding mechanisms and broad collaboration; and (2) To support a broad range of community-based child abuse and neglect prevention activities and family resource program services that support families.

The Community-Based Family Resource Center grant amounts are calculated in two parts. Fifty percent of the appropriation will be allotted based on the number of children under 18 in the State, with a minimum award of \$100,000 per State. The remaining fifty percent of the appropriation is allotted in an amount equal to 25% of the total amount allocated by each State to the State's trust fund or other pooled funding mechanism for integrating family resource services in Federal the fiscal year prior to the fiscal year for which the allotment is being determined.

Funds for the Community-Based Resource Program and the Temporary Child Care and Crisis Nurseries Program at the 1995 will be used to establish a network of local, culturally competent family resource programs that provide core services -- education and support services to improve parenting, early developmental screening of children, outreach, and follow-up -- and other direct services or referrals for services, including -- early care and education (including child care and Head Start), respite services, job training and counseling, education and literacy services, nutritional education, life management skills training, peer counseling and crisis intervention, family violence counseling, referrals for health (including prenatal care) and mental health services, substance abuse treatment, and services to support families of children with disabilities. In making local grant awards the State must give priority to programs

serving low income communities and those serving young parents or parents with young children.

Rationale for the Budget Request:

The FY 1997 request for the Community-Based Resource Program is \$50,569,000 an increase of \$40,734,000 over the comparable FY 1996 policy level. This represents level-funding at the FY 1995 level for a consolidation of the Community Based Family Resource Program and the Temporary Child Care and Crisis Nurseries program. This program is designed to assist States in implementing and enhancing a statewide system of community-based, family centered, family resource programs and child abuse neglect prevention through innovative funding mechanisms and broad collaboration with education, vocational, rehabilitation, health, mental health, employment and training, child welfare and other social services within the State.

Name of Program: Community-Based Family Resource Programs

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula <u>1</u> /	26,463,000	--	50,569,261
Discretionary	4,500,000	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	400,000	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	31,363,000	--	50,569,261
Number of Applicants	61	--	61
Number of Grants	61	--	56
New Starts:			
#	58	--	56
\$	26,863,000	--	50,569,261
Continuations:			
#	3	--	--
\$	4,500,000	--	--
Contracts:			
#	--	--	--
\$	--	--	--

1/ State formula grants.

Temporary Child Care and Crisis Nurseries

Authorizing Legislation - Section 206 of the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act of 1986, as amended. Expired 9/30/95.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$11,835,000	\$ 9,835,000	---	-\$9,835,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....None

Purpose and Method of Operations:

The Temporary Child Care and Crisis Nurseries program provides grants to States to demonstrate the effectiveness of two types of services: 1) temporary non-medical child care for children with special needs to alleviate social, emotional and financial stress among children and the families of such children; and, 2) crisis nurseries for children who are abused and neglected, at risk of abuse and neglect or who are in families receiving child protective services.

ACF awards grants to States through a competitive process to support demonstration projects by local governments and private non-profit agencies. One-half of available funds are to be used for grants for Temporary Child Care and one-half for Crisis Nurseries. The State may use up to five percent of its total funds for administrative costs.

The State is required to give priority consideration in the award of Temporary Child Care funds to agencies and organizations with experience in working with children with disabilities and chronically ill children and their families. The fees charged to families for temporary child care are based on a sliding fee schedule.

The State also is required to give priority consideration in the award of Crisis Nurseries funds to agencies and organizations with experience in working with abused and neglected children and their families. Crisis nurseries programs are required to provide referral to supportive services which can help address and resolve the family problems that lead to the crisis. There are no costs to families for crisis services for up to 30 days in any year.

For both programs, the State must give consideration to projects which serve communities demonstrating the greatest need for services.

Funding for the Temporary Child Care and Crisis Nurseries program during the last five years has been as follows:

1992.....	\$11,055,000
1993.....	\$11,942,000
1994.....	\$11,942,000
1995.....	\$11,835,000
1996.....	\$ 9,835,000

Rationale for the Budget Request:

In FY 1997, the Temporary Child Care and Crisis Nurseries Program is proposed to be consolidated into the Community Based Family Resource Program.

Name of Program: Temporary Child Care and Crisis Nurseries

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	--	--	--
Research	--	--	--
Demonstration	11,092,000	9,044,000	--
Development	--	--	--
Training/Technical Assistance	520,000	550,000	--
Evaluation	--	--	--
Program Support <u>1/</u>	223,000	241,000	--
Other			
TOTAL PROGRAM	11,835,000	9,835,000	--
Number of Applicants	--	55	--
Number of Grants	56	50	--
New Starts:			
#	--	22	--
\$	--	3,394,000	--
Continuations:			
#	56	28	--
\$	11,612,000	6,200,000	--
Contracts:			
#	1	2	--
\$	223,000	241,000	--

1/ Printing and misc. administrative expenses including: subscriptions, program support logistics contract and meeting support.

Family Violence

Authorizing Legislation - Sections 310 and 311(g) of the Family Violence Prevention and Services Act, as amended.

<u>1995 Enacted</u>	<u>1995a/ Policy</u>	<u>1996 Estimate</u>	<u>Increase or Decrease</u>
\$32,619,000	\$32,619,000	\$32,619,000	---

a/ Based on levels of ninth CR, including an incremental policy adjustment.

1997 Authorization:.....\$60,000,000

Purpose and Method of Operation:

The Family Violence Prevention and Services program provides grants to States and over 120 Indian Tribes to assist in supporting programs and projects to prevent incidents of family violence and provide immediate shelter and related assistance for victims of family violence and their dependents.

By statute, 80 percent of Family Violence funds are awarded in grants to States. State grants are allocated based on the State's population. Grants to territories and insular areas are equal to one-eighth of 1 percent of the amounts available for grants for that fiscal year.

The Act specifies that a State may keep 5 percent of its allotment for administrative costs and must distribute the remaining funds to local public agencies and non-profit private organizations, including religious and charitable organizations and voluntary associations. Sixty percent of the funds must be used to provide immediate shelter and related assistance to victims of family violence and their dependents. Most States exceed the 60 percent requirement. States may use the remaining funds to: establish new shelters in under-served areas; expand counseling, self-help, and substance abuse services; set up demonstrations programs, e.g., elder abuse shelters; or, provide training for staff and volunteers.

By statute, 10 percent of Family Violence funds is allocated for grants to Indian Tribes and tribal organizations. The amount of the Indian grants is based on the population of the tribe. Tribes use these funds primarily for emergency shelter and related assistance. Grants under the Act have assisted Tribes to focus on and improve services to victims and their families. Some Tribes also have used these funds for public education efforts to break patterns of alcoholism and family violence.

The statute also authorizes ACF to fund activities relating to the issue of family violence through grants, contracts or interagency agreements. These activities include funding of State domestic violence coalitions to further the purposes of domestic violence intervention and prevention; the training of law enforcement personnel by the Department of Justice; support for a National Resource Center and Special Issue Resource Centers; research activities with the Department of Justice; and the provision of technical assistance in the conduct of programs for the prevention and treatment of family violence.

Funding for the Family Violence Prevention and Services program during the last five years has been as follows:

1992.....	\$20,000,000
1993.....	\$24,678,619
1994.....	\$27,679,000
1995.....	\$32,645,000
1996.....	\$32,619,000

Rationale for the Budget Request

The request for FY 1997 of \$32,619,363 is the same as the FY 1996 policy level. The FY 1997 funding provides the basis for the continuation of these important activities which directly support the State's efforts for the successful prevention of and intervention in the cycle of violence. This program directly impacts the lives of victims, survivors and their dependents. It enables the Secretary to support more than 1800 service sites for abused women and their dependents which include more than 1200 shelters.

Name of Program: Family Violence Prevention and Services

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	\$27,133,000	\$27,107,000	\$27,107,000
Discretionary	871,000	576,000	976,000
Coalitions	2,415,000	2,500,000	2,500,000
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	1,507,000	1,506,000	1,506,000
Evaluation	---	---	---
Program Support	79,190 <u>1/</u>	765,000	365,000 <u>3/</u>
Other	614,000 <u>2/</u>	165,000	165,000 <u>5/</u>
TOTAL PROGRAM	\$32,619,000	\$32,619,000	\$32,619,000
Number of Applicants	196	216	216
Number of Grants	196	216	216
New Starts:			
#	192	212	208
\$	30,973,000	31,754,000	30,583,000
Continuations:			
#	4	4	6
\$	1,507,000	525,000	1,656,000
Contracts:			
#	1	4	5
\$	139,000 <u>3/</u>	340,000	380,000 <u>4/</u>

1/ Interagency Agreements: Administration on Aging, \$250,000; National Academy of Science, \$125,000; Department of Justice, and Office of Juvenile Delinquency Prevention, \$50,000. Contracts: Native American Technical Assistance, \$100,000; Hispanic Symposium on Family Violence, \$100,000; Institute on Domestic Violence in the African American community, \$75,000; Grantee Conference on Family Violence, \$65,000.

2/ National Domestic Violence Hotline Transfer Data Acquisition \$100,000; Discretionary Program Reviews, \$65,000.

3/ Interagency Agreement: Department of Justice, Office of Juvenile Delinquency Prevention, \$50,000. Contracts: Native American Technical Assistance, \$100,000; Hispanic Symposium on Family Violence, \$75,000; Institute on Domestic Violence in the African American Community, \$75,000; Grantee Conference on Family Violence, \$65,000.

4/ Native American T/TA, \$100,000; Hispanic Symposium, \$75,000; African American Institute, \$75,000; Grantee Conference, \$65,000; Discretionary Program Reviews, \$65,000.

5/ Native American T/TA, \$100,000 and Grantee Conference, \$65,000.

Comprehensive Runaway and Homeless Youth Program

Authorizing Legislation - Section 311 of Part A of the Runaway and Homeless Youth Act, as amended; Section 3511-3515 of the Anti-Drug Act of 1988, as amended; and Section 321(a) of Part B of the Runaway and Homeless Youth Act, as amended.

<u>1995</u> <u>Enacted</u>	<u>1996a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
--	--	\$68,572,180	+\$68,572,180

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

FY 1997 Authorization. New authorizing legislation will be proposed for the Consolidation.

Purpose and Method:

Under current law, an agency attempting to provide comprehensive services to this population must compete for funding under the three, separate categorical programs. This piecemeal approach results in unnecessary and duplicative administrative efforts at the local level. The consolidated program would significantly relieve the burdens associated with applying for and administering grants from several Federal programs. Further, local communities would have greater flexibility to meet their most immediate needs and best serve runaway and homeless youth.

The comprehensive runaway and homeless youth program establishes a single discretionary program to provide comprehensive services at the local level for runaway and homeless youth to replace the three separate program authorities now in existence. Under the new consolidated program, grant applicants could seek funding to provide a wide range of services for runaway and homeless youth and their families, including one or more of the following: emergency intervention services, transitional living services, drop-in and drug abuse prevention services.

Funds available for these comprehensive service grants would be allotted among the states using the current RHYP allocation formula. Competitive grants would be awarded directly to service providers by the Federal Government for the purpose of establishing and operating local runaway and homeless youth centers to meet the emergency and transitional living needs, including drug abuse prevention and intervention, of the target population. Priority would be given to agencies with experience in providing services to runaway and homeless youth.

Authority for grants and contracts for training and technical assistance; research, demonstration, and evaluation; and the runaway hotline would be maintained. Ninety percent of the total appropriation would be designated for comprehensive service and demonstration projects that include one or more of the currently authorized services.

This program will facilitate the provision of comprehensive, integrated services for runaway and homeless youth and would eliminate duplication of administrative burdens associated with receiving grants from separate Federal, discretionary grant programs. Further, local communities would have greater flexibility to meet their most immediate needs and best serve runaway and homeless youth.

Rationale for the Budget Request:

The FY 1997 request of \$68,572,000 for the Comprehensive Runaway and Homeless Youth Program is an increase of \$11,423,000 over the FY 1996 policy level of \$57,149,000. This funding level will serve to maintain services for an extremely vulnerable population. These services are available through no other legislation.

The request will efficiently support, more than 630 existing runaway and homeless youth centers that currently provide emergency shelters, residential programs, family and individual counseling, life skills training, drug prevention activities and other services needed by youth in at-risk situations. These funds also support a national runaway hotline and a training and technical assistance network.

The new program will be phased in so as not to disrupt services provided by existing programs. Each applicant for a Comprehensive Runaway and Homeless Youth Program grant will be able to identify the services that are most needed in the local community and will be able to apply for a grant to implement these services through a single application rather than through the three applications that are currently required.

The range of services that will be authorized for implementation under the consolidation will include short-term shelter for up to 15 days; the provision of food, clothing, counseling, referrals and related services addressing the immediate needs of runaway and homeless youth; interventions to prevent and reduce the use of illicit drugs by runaway and homeless youth; and long-term shelter for older homeless youth up to 18 months with the provision of training and practice in developing the skills, knowledge, and values required for independent living as adults outside the welfare system.

Name of Program: Comprehensive Runaway and Homeless Youth

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	62,836,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	1,000,000
Development	--	--	--
Training/Technical Assistance	--	--	3,119,000
Evaluation	--	--	--
Program Support 1/	--	--	617,000
Other 1/	--	--	1,000,000
TOTAL PROGRAM	--	--	68,572,000
Number of Applicants	--	--	675
Number of Grants	--	--	425
New Starts:			
#	--	--	50
\$	--	--	15,072,000
Continuations:			
#	--	--	375
\$	--	--	50,000,000
Contracts:			
#	--	--	6
\$	--	--	3,500,000

1/ Includes peer reviews, youthnet, switchboard.

Runaway and Homeless Youth

Authorizing Legislation - Section 385(a)(1) of the Runaway and Homeless Youth Act, as amended..

<u>1995</u> <u>Enacted</u>	<u>1996a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$40,458,000	\$43,500,000	---	-\$43,500,000

a/ Based on levels of the ninth CR, including an incremental policy adjustments.

1997 Authorization.....None

Purpose and Method of Operations:

The Runaway and Homeless Youth Program provides grants to local public and private organizations to establish and operate local runaway and homeless youth centers to address the crisis needs of runaway and homeless youth and their families. Grants are used to develop or strengthen community-based centers which are outside the law enforcement, juvenile justice, child welfare and mental health systems. The Runaway and Homeless Youth Act mandates that 90 percent of the program funds be used to establish and operate basic centers which meet the immediate needs of runaway and homeless youth. By statute, funds are allocated among States based on each State's population under 18 years of age. Applications are selected for funding through a competitive review process.

In addition to the funds which directly support temporary shelters for runaway and homeless youth, approximately 10 percent of the funds in each of the past five years have been used to fund projects which support and strengthen the work of the shelters. These include: the national toll-free runaway and homeless youth hotline, for which the Act earmarks \$826,900 in FY 1994; training and technical assistance activities; research and demonstration projects on a wide variety of topics; increasing utilization of centers by minority youth; and methods to improve program administration, outreach, and prevention activities among local shelters.

Funding levels for the last five years have been as follows:

1992.....	\$35,751,000
1993.....	\$35,110,000
1994.....	\$36,110,000
1995.....	\$40,458,000
1996.....	\$43,500,000

Rationale for the Budget Request:

In FY 1997, this program has been proposed for consolidation under the Comprehensive Runaway and Homeless Youth Program.

Name of Program: Runaway and Homeless Youth

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	36,524,000	39,566,000	--
Research	--	--	--
Demonstration	708,000	708,000	--
Development	--	--	--
Training/Technical Assistance	2,052,000	2,052,000	--
Evaluation	--	--	--
Program Support	83,000	83,000	--
Other <u>1/</u>	1,091,000	1,091,000	--
TOTAL PROGRAM	40,458,000	43,500,000	--
Number of Applicants	300	300	--
Number of Grants	510	390	--
New Starts:			
#	160	90	--
\$	14,441,000	11,142,000	--
Continuations:			
#	350	300	--
\$	24,748,000	31,089,000	--
Contracts:			
#	7	7	--
\$	1,269,000	1,269,000	--

1/ Includes peer reviews, youthnet, switchboard.

Transitional Living for Homeless Youth

Authorizing Legislation - Section 385(b) (1) of the Runaway and Homeless Youth Act, as amended.

<u>1995</u> <u>Enacted</u>	<u>1996a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$13,649,000	\$13,649,000	----	-\$13,649,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....None

Purpose and Method of Operations:

The Transitional Living for Homeless Youth program provides grants to local public and private organizations to address the shelter and service needs of homeless youth. This program is designed to meet the more complex, long-term needs of homeless youth ages 16-21.

Grants are used to: (1) develop or strengthen community-based programs which assist homeless youth in making a smooth transition to a productive adulthood and social self-sufficiency; and (2) provide technical assistance to transitional living programs to enhance their capacity to acquire and maintain resources and service linkages in their local communities.

It is estimated that between one-third and one-half of all youth served by the current runaway and homeless youth centers are homeless either through mutual agreement with their families or because they have been pushed out by a parent or legal guardian.

A homeless youth accepted into the program is eligible to receive shelter and services continuously for up to 540 days (18 months). The services include: information and counseling services in basic life skills, such as money management and housekeeping; interpersonal skill building, such as decision-making and priority-setting; educational advancement; job attainment; and mental and physical health care.

Funding levels for the last five years have been as follows: -

1992.....	\$12,000,000
1993.....	\$11,785,000
1994.....	\$12,200,000
1995.....	\$13,649,000
1996.....	\$13,649,000

Rationale for the Budget Request:

In FY 1997, this program has been proposed for consolidation under the Comprehensive Runaway and Homeless Youth Program.

Name of Program: Transitional Living For Homeless Youth

Program Data:

	<u>FY 1995</u> <u>Enacted</u>	<u>FY 1996</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	13,220,000	13,220,000	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	429,000	429,000	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	13,649,000	13,649,000	--
Number of Applicants	150	150	--
Number of Grants	80	80	--
New Starts:			
#	37	--	--
\$	6,586,000	--	--
Continuations:			
#	43	80	--
\$	6,884,000	13,470,000	--
Contracts:			
#	3	3	--
\$	179,000	179,000	--

Drug Education and Prevention for Homeless Youth

Authorizing Legislation - Section 3513 of the Anti-Drug Abuse Act of 1988, as amended.

<u>1995</u> <u>Enacted</u>	<u>1996a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$14,466,000	---	---	---

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....None

Purpose and Method of Operations:

The purpose of the Drug Education and Prevention for Runaway and Homeless Youth program is to reduce and prevent the illicit use of drugs by runaway and homeless youth. This is accomplished through research, demonstration and service grants awarded to public and private non-profit organizations. These projects are designed to: provide individual, family and group counseling to youth and their families to reduce or prevent drug abuse; develop and support peer counseling programs; develop and support community education programs including outreach to individual youth; provide assistance to runaway and homeless youth in rural areas through the development of support groups; provide training and information on drug abuse to persons involved in providing services to runaway and homeless youth; support research on the illicit use of drugs by runaway and homeless youth, and the effect on those youth of drug use by family members and any correlation between such use and suicide or attempted suicide; and, improve the availability and coordination of local service programs assisting runaway and homeless youth. This program also funds technical assistance to runaway and homeless youth service providers.

In selecting grantees, the statute requires ACF to give priority to agencies and organizations which have experience serving runaway and homeless youth.

Funding for the last five years has been as follows:

1992.....	\$15,286,808
1993.....	\$14,602,695
1994.....	\$14,603,000
1995.....	\$14,466,000
1996.....	None

Rationale for the Budget Request:

In FY 1997, this program has been proposed for consolidation under the Comprehensive Runaway and Homeless Youth Program.

Name of Program: Drug Education and Prevention for Homeless Youth

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	12,558,000	--	--
Research	--	--	--
Demonstration	532,000	--	--
Development	--	--	--
Training/Technical Assistance	1,116,000	--	--
Evaluation	59,000	--	--
Program Support	201,000	--	--
Other	--	--	--
TOTAL PROGRAM	14,466,000	--	--
Number of Applicants	200	--	--
Number of Grants	145	--	--
New Starts:			
#	62	--	--
\$	5,523,000	--	--
Continuations:			
#	83	--	--
\$	7,869,000	--	--
Contracts:			
#	7	--	--
\$	1,074,000	--	--

HHS Teenage Pregnancy Prevention Initiative

Authorizing Legislation - Section 1110 of the Social Security Act, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
--	--	\$30,000,000	--

1997 Authorization.....Such sums.

Purpose and Method of Operations:

Teen pregnancy rates remain alarmingly high in the U.S. President Clinton, recognizing the impact of this tragedy, has referred to teen pregnancy as one of our most serious social problems. Recent data indicate that the percentage of births to teenage mothers was 20 percent or greater in about 25 of the nation's largest cities. Many mid-sized cities and local communities have similar statistics. It is clear that this problem is a national one, affecting urban, suburban and rural areas alike.

The HHS Teenage Pregnancy Prevention Initiative will provide demonstration grants to local communities to develop, expand or strengthen promising strategies for meeting the developmental needs of young men and young women, to prevent teenage pregnancy. The President's principal objective for this new initiative is to sustain as well as build on this progress, to support and enhance local community efforts, and to increase the scope of local initiatives to help families and youth.

The Department will seek input from individuals or groups working in the field in both developing the criteria for selection of projects as well as the selection process itself. Applications will be accepted through a competitive review process.

Projects in which non-federal stakeholders either contribute through matching funds and/or in-kind services will be given priority for this initiative.

A broad range of uses of the funds will be authorized with special priority on those that have been shown through research, to have a positive effect on youth development and, therefore, on teenage pregnancy reduction. These strategies provide opportunities for young people to take responsibility, increase their competence, and make progress toward becoming contributing members of adult society. A wide variety of integrated approaches to preventing teenage pregnancy could be supported, with multiple components, such as skills building, information

giving, group support, service provision and life options building. Types of activities might include abstinence-based activities, school health, family planning, alcohol and drug use prevention and referral for treatment, academic tutoring, literacy training, drop-out prevention programs, career and college counseling, mentoring, job skills training, apprenticeships, part-time paid work, community service programs, and local media campaigns. The funding can be used to fill gaps in services, ensure coordination of services, and other similar activities. In addition, the funds would be used to document and evaluate the effectiveness of the expanded strategies or enhancements supported under this and other existing initiatives.

The demonstrations should involve many sectors of the community, including the business, voluntary, media, law enforcement, education, and religious, as well as the health and social services sectors. They will seek to enhance individual and community responsibility as well as directly support youth and families.

Rationale for the Budget Request:

The FY 1997 budget request is \$30,000,000. The Department's work in the area of youth development and teenage pregnancy prevention to date confirms that in order to help communities move to a greater level of effectiveness in combatting teenage pregnancy, a significant infusion of resources is necessary -- there are many communities that have significant teenage pregnancy problems, but do not have resources available to address them. The HHS Teenage Pregnancy Prevention Initiative will fund 25 projects at \$1 million each.

In addition to funds to provide direct services or activities that will demonstrate the effectiveness of prevention strategies, approximately \$5 million of the funds will be used to cover the cost of evaluation, training, technical assistance and development of new outcome measures and methodologies.

Name of Program: Teen Pregnancy Prevention Initiative

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	--	--	20,000,000
Research	--	--	--
Demonstration	--	--	5,000,000
Development	--	--	--
Training/Technical Assistance	--	--	1,500,000
Evaluation	--	--	1,500,000
Program Support <u>1/</u>	--	--	1,000,000
Other <u>1/</u>	--	--	1,000,000
TOTAL PROGRAM	--	--	30,000,000
Number of Applicants	--	--	500
Number of Grants	--	--	25
New Starts:			
#	--	--	25
\$	--	--	25,000,000
Continuations:			
#	--	--	--
\$	--	--	--
Contracts:			
#	--	--	5
\$	--	--	5,000,000

1/ Includes peer reviews and other expenses.

Child Abuse State Grants

Authorizing Legislation - Section 114 of the Child Abuse Prevention and Treatment Act, as amended. Expired 9/30/95.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$22,854,000	\$22,854,000	\$22,854,000	---

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Authorizing legislation expired 9/30/95. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operations:

The Child Abuse and Neglect State Grant program provides grants to States to improve each State's child protective service system. Grants are based on the population of children under the age of 18 in each State that applies for a grant.

In past years, this program served as a catalyst to assist States to: develop and strengthen programs of prevention and treatment; educate law enforcement and judicial personnel in the causes, problems, and management of child abuse and neglect; improve 24-hour capability to respond to reports of child abuse and neglect; improve the management of sexual abuse and medical neglect cases; establish and strengthen self-help groups; recruit and train volunteers; develop crisis hotlines; disseminate information on child abuse and neglect to schools, hospitals, day care centers, and runaway and homeless youth facilities; develop statewide public awareness campaigns; and establish programs and procedures for the identification, prevention and treatment for the growing numbers of infants/children victimized by substance abusers.

Funding for the Child Abuse and Neglect State grant program during the last five years has been as follows:

1992.....	\$20,518,000
1993.....	\$20,353,856
1994.....	\$22,854,000
1995.....	\$22,854,000
1996.....	\$22,854,000

Rationale for the Budget Request:

The FY 1997 budget request is \$22,854,000, the same as the FY 1996 policy level. Current research and data collection efforts indicate increasing numbers of child abuse and neglect reports and greater severity in outcomes and forms of maltreatment. Continued support for this program will help contain and resolve problems in the child abuse and neglect area.

FY 1997 funds will support activities in the areas of: the intake and screening of reports of child abuse and neglect; investigating reports of abuse and neglect; creating and improving multi-disciplinary teams and interagency protocols to enhance investigations; improving legal preparation and representation; improving case management; and, improving assessment tools, automated systems, information referral systems and staff training.

Name of Program: Child Abuse State Grants

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula 1/	22,854,000	22,854,000	22,854,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	22,854,000	22,854,000	22,854,000
Number of Applicants	51	51	51
Number of Grants	51	51	51
New Starts:			
#	51	51	51
\$	22,854,000	22,854,000	22,854,000
Continuations:			
#	--	--	--
\$	--	--	--
Contracts:			
#	--	--	--
\$	--	--	--

1/ Estimates based on the assumption that all states will be eligible.

Child Welfare Services

Authorizing Legislation - Section 420, title IV-B of the Social Security Act, as amended.

<u>1995 Enacted</u>	<u>1996 Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$291,989,000	\$291,989,000	\$291,989,000	---
1997 Authorization.....			\$325,000,000

Purpose and Method of Operations

The Child Welfare Services program helps State public welfare agencies improve their child welfare services with the goal of keeping families together. State services include: preventive intervention so that, if possible, children will not have to be removed from their homes; services to develop alternative placements like foster care or adoption if children cannot remain at home; and, reunification so that children can return home if at all possible. Child welfare services are available to children and their families without regard to income.

Funds are distributed to States in the form of grants. Each State receives a base amount of \$70,000. Additional funds are distributed in proportion to the State's population of children under age 21 multiplied by the complement of the State's average per capita income. The State match requirement is 25 percent.

Prior to October 1, 1996, all States were eligible to receive a share of the first \$141 million appropriated for Child Welfare Services. However, as an incentive to States, only those States which had implemented the specific protections for children contained in P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, were eligible to share in any amount appropriated for this program in excess of \$141 million. After October 1, 1996, the money in excess of \$141 million also becomes part of the basic grant. No more incentive funds are available.

The 1980 amendments to the Social Security Act link this program (Title IV-B) to the Title IV-E-Foster Care and Adoption Assistance Programs. The same State agency must administer, or supervise the administration of the programs. The broad goal of all the programs is to strengthen families in which children are at risk. The 1993 amendments to the Social Security Act created the new Family Preservation and Support Services Program as subpart 2 of the Title IV-B Program and joined it to this program (now subpart 1 of Title IV-B) and to the Title IV-E programs. The same State agency must administer, or supervise the administration of the programs. Taken together, these programs

provide a continuum of services to help children and their families.

Effective October 1, 1996 protections which States had to implement to receive the incentive funds under the Child Welfare Services Program became State Plan requirements in Section 422 and include: (1) conducting an inventory of all children in foster care for at least six months; (2) establishing an information and locator system for all children in foster care; (3) conducting periodic case reviews of all foster children; (4) providing due process protection for families; and, (5) conducting in-home and permanent placement service programs, including preventive and reunification services.

Since 1983, under Section 428 of the Social Security Act, grants have been awarded directly to eligible Indian tribal organizations meeting State plan requirements for child welfare services. In FY 1994, grants totaling \$956,319 were made to sixty-two Indian Tribal Organizations. All of the funds were awarded from the allotment of the States in which the Indian Tribal Organizations are located.

Funding for the Child Welfare Services program during the last five years has been as follows:

1992.....	\$273,911,000
1993.....	\$294,624,000
1994.....	\$294,624,000
1995.....	\$291,989,000
1996.....	\$291,989,000

The appropriations cited above do not include additional funds States voluntarily transfer to Title IV-B Child Welfare Services from Title IV-E Foster Care.

Rationale for the Budget Request:

The FY 1997 request for the Child Welfare Services program is \$291,989,000, the same as the FY 1996 policy level.

These funds will enable States to continue to provide services aimed at assisting children and their families in achieving the best and most appropriate outcome for the child -- preventing the placement of the child in foster care, helping the child return home from foster care, or enabling families to adopt the child.

Name of Program: Title IV-B Child Welfare Services

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	291,989,000	291,989,000	291,989,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	291,989,000	291,989,000	291,989,000
Number of Applicants	122	130	130
Number of Grants	122	130	130
New Starts:			
#	--	8	8
\$	--	50,000	50,000
Continuations:			
#	--	122	122
\$	291,989,000	291,939,000	291,939,000
Contracts:			
#	--	--	--
\$	--	--	--

Child Welfare Innovative Program

Authorizing Legislation - None

<u>1995</u> <u>Enacted</u>	<u>1996a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
---	---	39,178,000	+39,178,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Authorizing legislation will be proposed.

Purpose and Method of Operation:

This program is a proposed consolidation of four currently funded discretionary programs: Child Abuse and Neglect discretionary grants, Adoption Opportunities, Section 426 Research and Demonstration and Section 426 Training.

The general purpose of the Child Welfare Innovative program is to fund programs designed to facilitate the development of new knowledge, policy and programs and to address emerging issues in the field. This program will fund grants and contracts to public and private organizations to support research, demonstration, evaluation, training and technical assistance activities for children, youth and families in the areas of child welfare and child abuse and neglect. Applications will be selected for funding through a competitive review process.

Rationale for the Budget Request:

No new funds are being requested. The funding for this program totals the amount derived from the programs which are being consolidated. These funds will be used strategically and flexibly to provide critical, knowledge-based support for child welfare reform in states and communities by supporting research, demonstration, evaluation, training and technical assistance designed to address emerging issues in the areas of child welfare and child abuse and neglect.

Because of the new funding authority, there will be more flexibility than was possible under the four separate programs which form the basis of this consolidated program. Separate programmatic priorities will be established and funded without the restrictions imposed by the individual programs. Research, demonstrations, and evaluations in areas such as relative care, institutional placements, guardianship, special needs adoption, or innovative approaches to collaboration and coordination of

services will be possible to an extent that was previously impossible. This flexibility is necessary and appropriate at a time when reports of child abuse and neglect keep growing and the numbers of children entering foster care continues to grow, without the concomitant increase in federal and state funds. This program will give us the possibility of developing and evaluating new and better ways of addressing the needs of children and families.

Name of Program: Child Welfare Innovative Program

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	--	--	--
Research	--	--	13,000,000
Demonstration	--	--	16,250,000
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	3,000,000
Program Support <u>1</u> /	--	--	4,928,000
Other <u>1</u> /	--	--	2,000,000
TOTAL PROGRAM	--	--	39,178,000
Number of Applicants	--	--	200
Number of Grants	--	--	177
New Starts:			
#	--	--	75
\$	--	--	17,678,000
Continuations:			
#	--	--	102
\$	--	--	16,300,000
Contracts:			
#	--	--	15
\$	--	--	5,200,000

1/ Printing and other expenses including: subscriptions, program support logistics contract and meeting support.

Child Welfare Training

Authorizing Legislation - Section 426 of title IV-B of the Social Security Act, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$4,398,000	\$2,000,000	---	-\$2,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....None

Purpose and Method of Operations:

The Child Welfare Training program provides discretionary grants to public and private non-profit institutions of higher education to develop and improve education and training programs and resources for child welfare service providers. Applications are selected for funding through a competitive review process. These grants upgrade the skills and qualifications of child welfare workers through their participation, full-time or part-time, in programs focused specifically on child welfare services and provide traineeships to full-time students seeking undergraduate and advanced degrees. Activities supported include:

- o providing stipends to students to increase the numbers of trained workers in the field of child welfare, with emphasis on minority students;
- o improving the ability of State or local child welfare agencies to provide practice-relevant child welfare services training, or to implement staff development activities;
- o providing mechanisms to increase communication among post-secondary educational institutions and public child welfare agencies in the area of training;
- o providing interdisciplinary training in the field of child welfare.

Funding for the Child Welfare Training program during the last five years has been as follows:

1992.....	\$3,559,000
1993.....	\$4,441,184
1994.....	\$4,441,000
1995.....	\$4,398,000
1996.....	\$2,000,000

Rationale for the Budget Request:

This program is one of four proposed for consolidation into the Child Welfare Innovative Program.

Name of Program: Child Welfare Training

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	4,271,000	1,850,000	--
Evaluation	--	--	--
Program Support <u>1/</u>	127,000	150,000	--
Other	--	--	--
TOTAL PROGRAM	4,398,000	2,000,000	--
Number of Applicants	50	31	--
Number of Grants	49	31	--
New Starts:			
#	26	--	--
\$	1,791,000	--	--
Continuations:			
#	23	31	--
\$	2,480,000	1,850,000	--
Contracts:			
#	2	2	--
\$	127,000	150,000	--

1/ Printing and other expenses including: subscription, program support-logistics contract and meeting support.

Child Welfare Research and Demonstration

Authorizing Legislation - Section 426 of title IV-B of the Social Security Act, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$6,395,000	---	---	---

1997 Authorization.....None

Purpose and Method of Operations:

The Child Welfare Research and Demonstration program funds grants and contracts to public and private organizations to support activities which improve the services provided for children, youth and families in the child welfare system. This program funds a variety of research, demonstration and evaluation projects related to child welfare services. Applications are selected for funding through a competitive review process.

In recent years, these funds have supported demonstration projects in the following areas: specialized foster care for older children and for drug-exposed children, day treatment, family reunification, services to homeless families, State and Indian Tribal agreements, reducing child welfare agency staff turnover, mental health and child welfare services.

Research studies and evaluations are supported in the following areas: National Child Welfare Research Centers, National Study of the Recruitment and Retention of Foster Parents, National Study of Child Welfare Services Delivered to Children and Their Families, field initiated research by both new and experienced researchers, evaluation of homeless programs, study of the impact of substance abusing families on child welfare services, the development of systems to collect and analyze adoption and foster care data, and the collection and analyses of those data.

Finally, these funds support the provision of technical assistance to public child welfare agencies in the form of telephone and on-site consultation and the development and dissemination of materials by five Child Welfare Resource Centers.

Funding for the Child Welfare Research and Demonstration program during the last five years have been as follows:

1992.....	\$6,652,000
1993.....	\$6,652,000
1994.....	\$6,467,000
1995.....	\$6,395,000
1996.....	None

Rationale for the Budget Request:

This program is one of four proposed for consolidation into Child Welfare Innovative Programs.

Name of Program: Child Welfare Research & Demonstration

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	--	--	--
Research	1,429,000	--	--
Demonstration 1/	1,428,000	--	--
Development	--	--	--
Training/Technical Assistance	2,824,000	--	--
Evaluation	565,000	--	--
Program Support	--	--	--
Other 2/	149,000	--	--
TOTAL PROGRAM	6,395,000	--	--
Number of Applicants	27	--	--
Number of Grants	15	--	--
New Starts:			
#	6	--	--
\$	905,000	--	--
Continuations:			
#	10	--	--
\$	3,286,000	--	--
Contracts:			
#	19	--	--
\$	2,204,000	--	--

1/ Includes a \$250,000 transfer to the Commissioner on Child Family Welfare.

2/ Printing and other expenses including: subscription, program support-logistics contract and meeting support.

Adoption Opportunities

Authorizing Legislation - Section 205 of the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978, as amended. Expired 9/30/95.

<u>1995 Enacted</u>	<u>1996^a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$13,000,000	\$11,000,000	---	-\$11,000,000

^a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....None.

Purpose and Method of Operations:

The Adoption Opportunities program funds grants and contracts to public and private organizations to help eliminate barriers to adoption and help find permanent families for children who would benefit by adoption, particularly children with special needs.

The five major project areas, as mandated by the authorizing legislation, are: (1) the development and implementation of a national adoption and foster care data gathering and analysis system; (2) the development and implementation of a national adoption information exchange system; (3) the development and implementation of an adoption training and technical assistance program; (4) increasing the placements in adoptive families of minority children who are in foster care and have the goal of adoption with a special emphasis on recruitment of minority families; and (5) post-legal adoption services for families who have adopted children with special needs. In these areas, research and demonstration grants are awarded through a competitive process to public and private non-profit agencies including State and local governments, universities and voluntary agencies. Contracts may be awarded to non-profit or voluntary organizations.

When appropriations are in excess of \$5 million, the law requires the award of grants to States for improving State efforts to increase the placement of foster care children legally free for adoption (according to a pre-established plan and goals for improvement). These grants may not exceed \$1 million during any fiscal year.

Funding for the Adoption Opportunities program during the last five years has been as follows:

1992.....	\$12,687,000
1993.....	\$12,162,520
1994.....	\$12,163,000
1995.....	\$13,000,000
1996.....	\$11,000,000

Rationale for the Budget Request:

This program is one of four programs proposed for consolidation into the Child Welfare Innovative Program.

Name of Program: Adoption Opportunities

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	10,530,000	10,000,000	--
Research	200,000	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	1,753,000	--	--
Evaluation	--	--	--
Program Support <u>1/</u>	517,000	1,000,000	--
Other	--	--	--
TOTAL PROGRAM	13,000,000	11,000,000	--
Number of Applicants	160	160	--
Number of Grants	109	92	--
New Starts:			
#	42	50	--
\$	4,571,000	5,800,000	--
Continuations:			
#	67	42	--
\$	6,887,000	3,200,000	--
Contracts:			
#	5	5	--
\$	1,542,000	2,000,000	--

1/ Printing and other administrative expenses including: subscription, program support-logistics contract and meeting support.

Child Abuse Discretionary Activities

Authorizing Legislation - Section 114 of the Child Abuse Prevention and Treatment Act, as amended. Expired 9/30/95.

<u>1995</u> <u>Enacted</u>	<u>1996a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$15,385,000	\$15,385,000	---	-\$15,385,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....None.

Purpose and Method of Operations:

The Child Abuse and Neglect Discretionary Program funds a number of research, demonstration and service improvement grants and contracts. The program funds research on the causes, prevention, identification and treatment of child abuse and neglect; investigative, administrative and judicial procedures; and the national incidence of child abuse and neglect. The program also funds projects to: compile, publish and disseminate training materials; provide technical assistance; and demonstrate and evaluate improved methods and procedures to prevent and treat child abuse and neglect. In addition, the program funds several resource centers on issues relating to child abuse and neglect and the national Clearinghouse on Child Abuse and Neglect Information. The Clearinghouse gathers and disseminates information on promising programs of prevention and treatment and on the incidence of child abuse and neglect.

Research, demonstration and service improvement grants are awarded competitively to public and private nonprofit agencies, including State and local government agencies, universities and voluntary organizations. Contracts may be awarded to nonprofit or proprietary organizations. Projects supported by grants and contracts awarded under this program may run up to five years, depending upon the availability of funds.

Funding for the Child Abuse and Neglect Discretionary program during the last five years has been as follows:

1992.....	\$14,339,000
1993.....	\$15,927,239
1994.....	\$15,927,000
1995.....	\$15,385,000
1996.....	\$15,385,000

Rationale for the Budget Request:

This program is one of four proposed for consolidation into the Child Welfare Innovative Programs.

Name of Program: Child Abuse Discretionary Activities

Program Data:

	<u>FY 1995</u> <u>Enacted</u>	<u>FY 1996</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	--	--	--
Research	2,960,000	4,000,000	--
Demonstration	4,481,000	4,000,000	--
Development	--	--	--
Training/Technical Assistance	3,799,000	3,000,000	--
Evaluation	3,000,000	2,500,000	--
Program Support	--	--	--
Other <u>1/</u>	1,145,000	1,885,000	--
TOTAL PROGRAM	15,385,000	15,385,000	--
Number of Applicants	65	300	--
Number of Grants	64	63	--
New Starts:			
#	4	5	--
\$	993,000	1,769,000	--
Continuations:			
#	60	58	--
\$	9,634,00	6,681,000	--
Contracts:			
#	16	15	--
\$	4,758,000	7,385,000	--

1/ Included in this amount are funds for printing, logistics and supplies.

Abandoned Infants Assistant Program

Authorizing Legislation - Section 104(a) of the Abandoned Infants Assistance Act of 1988, as amended. Expired 9/30/95.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$14,406,000	\$12,406,000	\$14,406,000	+\$2,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Authorizing legislation expired September 30, 1995. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operations:

The Abandoned Infants Assistance program provides grants to public and nonprofit private entities for development, implementation and operation of projects to demonstrate how to: (1) prevent abandonment; (2) identify and address the needs of abandoned infants, especially those with AIDS and those born with drug dependence; (3) assist these children to reside with their natural families, if possible, or in foster care; (4) recruit, train and retain foster parents; (5) carry out residential care programs for abandoned children and children with AIDS; (6) establish programs of respite care for families and foster families; (7) recruit and train health and social services personnel to work with families, foster families and residential care staff. This program also funds technical assistance, including training, with respect to the planning, development and operation of the projects. All projects are evaluated.

Funding for the Abandoned Infants Assistance program during the last five years has been as follows:

1992.....	\$12,557,000
1993.....	\$13,562,624
1994.....	\$14,563,000
1995.....	\$14,406,000
1996.....	\$12,406,000

Rationale for the Budget Request:

The FY 1997 request for Abandoned Infants is \$14,406,000, an increase \$2,000,000 over the FY 1996 policy level. This amount will continue service demonstration grants to prevent the abandonment of infants and young children with AIDS and drug-exposed infants and young children and to reunify and strengthen families impacted by substance abuse.

Name of Program: Abandoned Infants Assistance

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	--	--	--
Research	1,000,000	--	--
Demonstration	12,664,000	11,331,000	13,331,000
Development	--	--	--
Training/Technical Assistance	600,000	600,000	600,000
Evaluation	--	150,000	150,000
Program Support <u>1/</u>	142,000	325,000	325,000
Other	--	--	--
TOTAL PROGRAM	14,406,000	12,406,000	14,406,000
Number of Applicants	--	110	110
Number of Grants	32	29	33
New Starts:			
#	--	24	28
\$	--	9,581,000	11,581,000
Continuations:			
#	32	5	5
\$	13,264,000	2,400,000	2,400,000
Contracts:			
#	2	3	3
\$	1,142,000	425,000	425,000

1/ Printing and other administrative expenses including: subscription, program support-logistics contract and meeting support.

Developmental Disabilities Basic State Grants

Legislative Authority - Section 130 of the Developmental Disabilities Assistance and Bill of Rights Act of 1990, as amended.

<u>1995</u> <u>Enacted</u>	<u>1996a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$70,438,000	\$70,438,000	\$70,438,000	-0-

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Authorizing legislation expires 9/30/96. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operation:

The Developmental Disabilities State Councils program assists each State to promote the development of a comprehensive, statewide, consumer and family-centered system which provides a coordinated array of culturally-competent services, supports and other assistance for individuals with developmental disabilities. In order to qualify for funds, States must submit a plan to the Administration on Developmental Disabilities and establish a State Developmental Disabilities Council to plan and advocate for the broad spectrum of developmental disabilities. Up to fifty percent of the Council's membership includes representatives of major State agencies, nongovernmental agencies and other concerned groups. At least fifty percent of the membership must include persons with developmental disabilities, their guardians and other relatives. Councils engage in a broad range of activities including, but not limited to, program and policy analysis, demonstration of new approaches, training, outreach, supporting communities, interagency collaboration and coordination, public education, and prevention.

Developmental Disabilities State Councils funds are allotted among the States on the basis of: population, the extent of need for services for persons with developmental disabilities, and the financial need of the respective States. By statute, the minimum allotment to each State is now the greater of \$420,475 or what they received in fiscal years 1992 and 1993, and the minimum allotment to each of the Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the Republic of Palau (until the Compact of Free Association with Palau takes effect) is now the greater of \$220,750 or what they received in fiscal years 1992 and 1993. The grants are made to designated state agencies to support the Councils in implementing

the approved State plan. The aggregate Federal share of projects under such grants may not exceed seventy-five percent except in the case of projects in poverty areas, in which case the Federal share may not exceed ninety percent, or in the case of projects conducted by Council members or staff, in which case the Federal share may be up to one hundred percent.

Funding for the Developmental Disabilities State Councils program during the last five years has been as follows:

1992.....	\$67,706,000
1993.....	\$67,372,000
1994.....	\$69,343,000
1995.....	\$70,438,000
1996.....	\$70,438,000

Rationale for the Budget Request:

The FY 1997 request is \$70,438,000 the same as the FY 1996 policy level.

These funds will provide payments to States to conduct activities that increase the capacities and resources of agencies to develop, coordinate, or stimulate permanent improvement in systems of services for persons with developmental disabilities, with priority to those persons whose needs are not otherwise met under other health, education and human services programs.

The FY 1997 funds will also continue to support State activities focusing on policy analyses, systemic change and capacity building activities.

Name of Program: Developmental Disabilities Basic State Grants

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	70,438,000	70,438,000	70,438,000
Discretionary			
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support/	---	---	---
Other/	---	---	---
TOTAL PROGRAM	70,438,000	70,438,000	70,438,000
Number of Applicants	56	56	56
Number of Grants			
Total	56	56	56
New Starts:			
#	0	0	0
\$			
Continuations:			
#	56	56	56
\$	70,438,000	70,438,000	70,438,000
Contracts:			
#	---	---	---
\$	---	---	---
Total.....	70,438,000	70,438,000	70,438,000

Developmental Disabilities Protection and Advocacy

Legislative Authority - Section 143 of the Developmental Disabilities Assistance and Bill of Rights of 1990, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$26,718,000	\$26,718,000	\$26,718,000	-0-

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Authorizing legislation expires 9/30/96. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operation:

The Developmental Disabilities Protection and Advocacy (P&A) program provides grants to establish and maintain a protection and advocacy system in each State to protect the legal and human rights of all persons with developmental disabilities. P&A funding is allotted among the States based on a formula that takes into account the population, the extent of need for services for persons with developmental disabilities, and the financial need of each State. The protection and advocacy system must have the authority under this program to pursue legal, administrative, and other appropriate remedies or approaches, including the authority to investigate incidents of abuse and neglect and to access client records. The P&A system must be independent of any agency which provides such services.

By statute, the minimum allotment to each State is now the greater of \$254,508 or what they received in fiscal years 1992 and 1993, and the minimum allotment to each of the Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the Republic of Palau (until the Compact of Free Association with Palau takes effect) is now the greater of \$136,161 or what they received in fiscal years 1992 and 1993.

Funding for the Developmental Disabilities Protection and Advocacy program during the last five years has been as follows:

1991.....	\$20,982,000
1992.....	\$22,500,000
1993.....	\$22,506,000
1994.....	\$23,753,000
1995.....	\$26,718,000

Rationale for the Budget Request:

The FY 1997 request is \$26,718,000 the same as the FY 1996 policy level.

The activities of the Protection and Advocacy Systems have been increasing as more and more individuals realize the significance of the Americans with Disabilities Act and the role the Protection and Advocacy System can play under it on their behalf. Funding for this program will help States ensure: protection and advocacy for the legal and human rights of persons with developmental disabilities through outreach programs to unserved and underserved individuals, including persons facing communications barriers, and those who are culturally or geographically isolated; services to institutionalized persons; training of concerned citizens and persons with developmental disabilities; and other advocacy resources. Funds will also be used by grantees to provide such services as hotlines, information and referral, counseling and legal services, advocacy activities and training to service providers on the rights of person with developmental disabilities.

Name of Program: Developmental Disabilities Protection & Advocacy

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	26,718,000	26,718,000	26,718,000
Discretionary	---	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support/	---	---	---
Other/	---	---	---
 TOTAL PROGRAM	 26,718,000	 26,718,000	 26,718,000
 Number of Applicants	 57	 57	 57
Number of Grants			
Total	57	57	57
New Starts:			
#	---	---	---
\$	---	---	---
Continuations:			
#	57	57	57
\$	26,718,000	26,718,000	26,718,000
Contracts:			
#	---	---	---
\$	---	---	---
 Total.....	 26,718,000	 26,718,000	 26,718,000

Developmental Disabilities Projects of National Significance

Legislative Authority - Section 161 of the Developmental Disabilities Assistance and Bill of Rights Act of 1994, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$5,715,000	\$3,323,000	\$5,715,000	+\$2,392,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Authorizing legislation expires 9/30/96. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operation:

The Developmental Disabilities Projects of National Significance program provides funds to expand or otherwise improve the opportunities for individuals with developmental disabilities to achieve full independence, productivity and inclusion in American Society. Funds will be provided to national, State, and local public and non-profit private organizations for demonstration, training and technical assistance projects through a competitive grants/contracts process. These projects enhance the lives of individuals with developmental disabilities through the promotion of activities and models designed to enhance their ability to live, work and play in their communities.

Funding for the Developmental Disabilities Protection and Advocacy program during the last five years has been as follows:

1992.....	\$3,248,000
1993.....	\$3,034,000
1994.....	\$3,784,000
1995.....	\$5,715,000
1996.....	\$3,323,000

Rationale for the Budget Request:

The FY 1997 request is \$5,715,000 an increase of \$2,392,000 over the FY 1996 policy level. This level of funding will continue to support projects designed to increase and support the independence, productivity, and integration and inclusion into the community of individuals with developmental disabilities and

their families. These projects include leadership development for individuals and their families from culturally diverse backgrounds; early intervention; home ownership; personal assistance services; improving child care for children with disabilities; transition from school-to-work activities; juvenile justice issues; strengthening families through self-advocacy and empowerment; data collection on public expenditures, employment and economic status, and housing; health care reform issues; and policy development. This program also provides technical assistance to improve the functions of the Developmental Disabilities Councils, Protection and Advocacy Systems, and the University Affiliated Programs.

Name of Program: Developmental Disabilities Projects of National Significance

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	---	---	---
Discretionary			
Research	---	---	---
Demonstration	\$3,785,000	\$2,883,000	\$4,878,000
Development	---	---	---
Training/Technical Assistance	\$1,556,000	\$250,000	\$647,000
Evaluation	---	---	---
Program Support	\$100,000	\$100,000	\$100,000
Other 1/	\$274,000	\$90,000	\$90,000
TOTAL PROGRAM	\$5,715,000	\$3,323,000	\$5,715,000
Number of Applicants	---	---	---
Number of Grants	---	---	---
Total			
New Starts:	2	3	8
#			
\$	200,000	600,000	834,000
Continuations:	9	11	22
#			
\$	\$3,785,000	\$2,473,000	\$4,045,000
Contracts:			
#	6	2	7
\$	\$1,330,000	\$250,000	\$837,000

1/ Interagency Agreement

Developmental Disabilities University Affiliated Program

Legislative Authority - Section 151 of the Developmental Disabilities Assistance and Bill of Rights of 1994, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$18,979,000	\$15,087,000	\$18,979,000	+3,892,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Authorizing legislation expires 9/30/96. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operation:

The Developmental Disabilities University Affiliated Program provides grants for operational and administrative support to a national network of 60 University Affiliated Programs (UAPs). Grantees are public or private non-profit agencies affiliated with a university and are initially selected through a competitive process. UAPs provide community services on behalf of persons with developmental disabilities through a variety of mechanisms including clinical services programs, community-based services programs, technical assistance to community services personnel and State agencies, and dissemination of information.

In addition to core support grants, the program provides 59 training grants to UAPs for interdisciplinary education, community service activities, technical assistance and information dissemination activities.

Grant funds are distributed in accordance with the Developmental Disabilities Assistance and Bill of Rights Act Amendments of 1994 in the following order of funding priorities:

(1) existing State UAPs, (2) establishing University Affiliated Program (UAP) in those States and territories currently without a UAP, and (3) ensuring that all eligible UAPs have a training initiative project.

Funding for the Developmental Disabilities University Affiliated Program during the last five years has been as follows:

1992.....	\$16,030,000
1993.....	\$16,124,960
1994.....	\$18,281,000
1995.....	\$18,979,000
1996.....	\$15,087,000

Rationale for the Budget Request:

The FY 1997 request is \$18,979,000 , an increase of \$3,892,000 over the FY 1996 policy level.

Programs will provide operational and administrative support to catalyze additional funding for a national network of University Affiliated Programs. Grants will provide interdisciplinary training, community services, technical assistance, and information dissemination activities. In addition to core support grants to the UAP, awards are made to support training projects in the areas of emerging national significance, specifically projects to train personnel in the areas of: assistive technology services, positive behavioral supports, transition from school-to-work community services, aging, early intervention, the Americans with Disabilities Act, and projects of special concern to the UAP which shall be developed in consultation with the State Developmental Disabilities Council.

Name of Program: Developmental Disabilities University
 Affiliated Program

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:	---	---	---
Formula			
Discretionary			
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	\$18,679,000	\$14,787,000	\$18,679,000
Evaluation	---	---	---
Program Support	\$300,000	\$300,000	\$300,000
Other	---	---	---
TOTAL PROGRAM	\$18,979,000	\$15,079,000	\$18,979,000
Number of Applicants	120	120	121
Number of Grants	120	77	121
Total New Starts:			
#	7	0	61
\$	\$630,000	0	8,059,000
Continuations:			
#	113	120	60
\$	\$18,049,000	\$14,787,000	\$10,620,000
Contracts:			
#	2	2	2
\$	\$300,000	\$300,000	\$300,000

Native American Program

Legislative Authority - Sections 816(a) and 803A (f) (1) of the Native American Programs Act of 1974, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$38,382,000	\$35,000,000	\$38,382,000	+\$3,382,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Reauthorizing legislation expired 9/30/95. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operation:

The Native American Programs Act is the only Federal program serving all Native Americans regardless of where they live or their tribal or group affiliation. The Native American Programs Act promotes self-sufficiency of American Indians, Alaska Natives, Native Hawaiians, and Native American Pacific Islanders by encouraging local strategies in economic and social development. The Administration for Native Americans (ANA) defines self-sufficiency as the level of development at which a Native American community can control and internally generate resources to provide for the needs of its members and meet its own short and long range social and economic goals. Social and economic underdevelopment are the paramount obstacles to the self-sufficiency of Native American communities and families.

Native American Programs include financial assistance for social and economic development and governance, training and technical assistance, research, demonstration and evaluation projects. Assistance is provided through direct grants, contracts and interagency agreements. These funds support projects that are expected to result in sustained improvements in the social and economic conditions of Native Americans within their communities, and at the same time, to increase the effectiveness of Indian tribes and Native American organizations to achieve their own economic and social goals.

Native American Programs and their policies foster a balanced developmental approach at the community level through three major goals: (1) Governance: To strengthen Tribal governments, Native American institutions and local leadership to assure local control over all resources; (2) Economic Development: To foster the development of stable, diversified local economies to provide jobs and reduce dependency on welfare services; and (3) Social

Development: To support local access to, and coordination of, services and programs which safeguard the health and well-being of Native Americans. These goals are based on the premise that the local Native American community has the primary responsibility for determining its own needs, for planning and implementing its own programs, and for building an economic base from its own natural, physical, and human resources.

The Administration for Native Americans' funding policy is to assist Indian Tribes and Native American organizations to plan and implement their own long-term strategies for social and economic development. This funding approach moves the focus from increasing dependency on social services to increasing the productivity of both individuals and communities.

Funding is based on the competitive selection of applications submitted by Indian tribes, Alaska natives and Native American organizations. Panels of outside individuals review and rate all applications according to published criteria and seek to identify those proposals most likely to produce permanent, beneficial change for Native American communities. Applicants must state specific, measurable goals based on the developmental needs of the community. After funding, grantees must report what they have accomplished based on the goals they set. Anticipated results include improved organizational effectiveness, new linkages with the private sector economy, and improved coordination of Federal and non-Federal resources to meet human needs in a developing economy.

Funding for the Native Americans Programs during the last five years has been as follows:

1992.....	\$34,126,000
1993.....	\$34,507,000
1994.....	\$38,627,000
1995.....	\$38,382,000
1996.....	\$35,000,000

Rational for the Budget Request:

The fiscal year 1997 request for Native American Programs is \$38,382,000, which is an increase of \$3,382,000 over the FY 1996 policy level.

It will support activities which cover a wide range of interrelated social and economic development efforts, including the expansion and creation of businesses and jobs in many areas, e.g., tourism, specialty agriculture, arts and crafts, cultural centers, light manufacturing, construction, health care systems, housing, day care, fishing, and fish resources.

The program also addresses governance projects which include the development of new and existing Tribal constitutions and by-laws, as well as the establishment of Tribal zoning, tax, environmental and other codes. These governance projects assist in creating a stable climate and the necessary legal infrastructure for villages and reservations, encouraging development and outside investments.

Status clarification is another important area within the program. This assists Tribes, Indian groups and villages to petition for Federal recognition. Subsequently, successful groups obtain assistance and resources from the Bureau of Indian Affairs and health and environmental services from the Indian Health Service.

Grants made under the Native American Languages Program will ensure the preservation and enhancement of Native American language programs. It will provide community based programs that (1) bring older and younger Native Americans together to facilitate and transfer a Native American language; (2) train Native Americans to teach, interpret, or translate a Native American language; (3) develop, print and disseminate materials to be used for teaching and enhancement purposes; (4) train Native Americans to produce or participate in television or radio programs to be broadcast in a Native American language; and, (5) compile, transcribe and analyze oral testimony to record and preserve a Native American language.

Grants made under the Indian Environmental Regulatory Enhancement Act will enable tribes to plan, develop and implement programs designed to improve their capacity to regulate environmental quality on Indian lands, in accordance with Federal and tribal laws and regulations. This competitive area provides financial assistance to Tribal and Alaska Village Governments to develop local environmental programs that respond to Tribal environmental goals. These include training professional staff to monitor and enforce tribal environmental programs, collection of base line data so Tribes can develop environmental statutes; and the identification of pollution in order to determine the impacts on existing environmental quality.

Name of Program: Administration for Native Americans

Program Data:

	<u>FY 1995</u> <u>Enacted</u>	<u>FY 1996</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>
Service Grants:			
Formula			
Discretionary	\$34,492,000	\$30,789,000	\$33,671,000
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	1,711,000	1,711,000	1,711,000
Evaluation	---	---	500,000
Program Support 1/	1,179,000	1,500,000	1,500,000
Other 2/	1,000,000	1,000,000	1,000,000
 TOTAL PROGRAM	 \$38,382,000	 \$35,000,000	 \$38,382,000
 Number of Applicants	 794	 798	 794
Number of Grants	259	239	259
New Starts:			
#	195	183	195
\$	\$21,714,000	\$20,189,000	\$21,714,000
Continuations:			
#	64	56	64
\$	\$12,230,000	\$9,911,000	\$12,230,000
Contracts:			
#	16	20	16
\$	\$4,438,000	\$4,900,000	\$4,438,000

1/ Preparation & logistical support for panel review process.

2/ Includes a grant to the Office of Hawaiian Affairs for the Native Hawaiian Revolving Loan Fund.

NATIVE AMERICAN PROGRAMS
(dollars in thousands)

	FY 1995 <u>Enacted</u>		FY 1996 <u>Policy</u>		FY 1997 <u>Request</u>	
	<u>No.</u>	<u>Amount</u>	<u>No.</u>	<u>Amount</u>	<u>No.</u>	<u>Amount</u>
I. <u>Federally Recognized Native Americans</u>						
A. Tribes	132	15,910	123	14,053	132	15,910
B. Alaska	42	5,255	39	4,641	42	5,255
C. Consortia	5	954	4	843	5	954
II. <u>Non-Federally Recognized Native Americans</u>						
A. Tribes	40	2,885	37	2,495	40	2,885
B. Urban	6	587	6	536	6	587
C. Rural	2	335	2	306	2	335
D. Consortia	7	1,096	5	968	7	1,096
III. <u>Native Hawaiians</u>	7	1,240	6	1,095	7	1,240
IV. <u>Native American Pacific Islanders</u>	2	322	3	350	2	322
V. <u>Special Projects</u>	15	4,360	13	3,813	15	4,360
VI. <u>Discretionary Activities</u>	16	4,438	20	4,900	16	4,438
VII. <u>Native Hawaiian Revolving Loan Fund</u>	1	1,000	1	1,000	1	1,000
TOTAL	275	\$38,382	259	\$35,000	275	\$38,382

Social Services Research and Demonstration

Legislative Authority - Section 1110 of the Social Security Act, as amended.

<u>1995 Enacted</u>	<u>1996a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$14,815,894	---	\$10,000,000	+10,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Such sums.

Purpose and Method of Operation

Social Services Research and Demonstration funds support cutting-edge research and evaluation projects in areas of critical national interest. These activities address the concerns of Congress -- through earmarks and provisions of law -- as well as the mission and goals of the Department.

The mission of the Department is to protect and promote the health, social, and economic well-being of all Americans. Specifically, Social Services Research and Demonstration funds address the goals of:

- o increased stability and economic independence for American families;
- o improved healthy development of children and youth; and
- o services that are more effective, cost less, and respond better to customer needs.

Projects are conducted through grants, contracts, and cooperative agreements. Evaluation results, policy implications, and data from projects are disseminated to other federal agencies, states, and others through publications (including final reports and information memoranda), conferences, and workshops.

Rationale for Budget Request

The FY 1997 budget request for Social Services Research and Demonstration funds is \$10,000,000, an increase of \$10 million over the FY 1996 policy level.

These funds will be used to support a number of new and ongoing projects that are providing important information on the design and operation of effective programs for America's families and

children. As greater responsibility is placed on state and local governments to design and implement programs to foster family responsibility and independence, and the healthy development of children, it is critical that they have available the necessary information to meet these responsibilities. The projects supported with these funds provide an opportunity to continually refine and test new approaches that build on the early success of completed and ongoing demonstration initiatives. The initial results and experience of these projects have been critical to decision makers in guiding national and state policy, particularly for programs aimed at increasing employment of low-income families, increasing child support enforcement and promoting responsible parenthood. Several key projects are highlighted which indicate the value of results of funded studies.

The JOBS evaluation, a major long-term study of the processes, impacts, and cost-effectiveness of the Job Opportunities and Basic Skills Training (JOBS) program, is designed to evaluate the effectiveness of alternative strategies for moving welfare recipients to work. Focusing on broad strategies will enable the results to be useful to program and policy design, independent of the existence of the JOBS program.

Another funded project is the Parents' Fair Share (PFS) Demonstration which tests the effects of requiring the unemployed non-custodial fathers of children on AFDC to participate in employment and other services designed to increase their earnings so they can adequately support their children. PFS programs in seven states have developed effective procedures to identify eligible fathers, enroll them into employment services and enforce regular participation. Preliminary data also shows that PFS work and training requirements provide states with a promising mechanism to discover previously unreported income of non-paying, non-custodial parents -- approximately 25 percent of the men in the program had previously unreported income. Because of PFS, Child Support Enforcement agencies have developed more responsive systems to complement work and training requirements. In FY 1997, the evaluator will determine whether training unemployed fathers, while at the same time providing courts with an alternate way to deal with non-paying parents, will enable these fathers to make regular child support payments and reduce their children's welfare dependency.

The ACF Responsible Fatherhood initiative, begun in FY 1995, also addresses parental responsibility by aiming to systematically develop credible information for states and localities about how to encourage and increase responsible conduct among fathers of disadvantaged children. Five community-based organizations (chosen from 149 applications from every region of the country) are currently operating programs to teach fathers how to understand their children's development and positively affect

their children's behavior. The experiences of these programs, ACF-supported research and analysis by the University of Minnesota Fatherhood Research Group, and the results of an ASPE-supported evaluation development project will be combined to help the federal government, states, localities, and private organizations understand how programs should be designed to enable parents, especially fathers, to support and nurture a child and how program effectiveness should be evaluated.

Finally, a wealth of change is occurring in the welfare system now as a result of waiver demonstrations. This represents the opportunity to learn critical operational lessons that could help states as they move forward with welfare reform. For example, many states are testing: requiring teen parents to attend school or training, requiring minor parents to live at home or in other structured living settings, increased participation in JOBS, more regular applications of larger sanctions for non-cooperation with child support and JOBS requirements, and encouraging savings through the establishment of special purpose accounts. One funded project has provided states with very useful operational lessons on how other states have increased participation in employment and training activities. Similar implementation studies in other areas could provide equally invaluable lessons to states in their reform efforts.

Name of Program: Section 1110 Social Services Research and Demonstration

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants			
Formula	---	---	---
Discretionary	---	---	---
Research	2,759,000	---	1,000,000
Demonstration	1,166,000	---	3,500,000
Training/Technical Assistance	370,000	---	500,000
Evaluation	3,191,000	---	5,000,000
Program Support 1/	6,731,000	---	---
Other 2/	<u>744,000</u>	<u>---</u>	<u>---</u>
TOTAL PROGRAM	14,961,000	---	10,000,000
Number of Applicants	275	---	300
Number of Grants	35	---	40
New Starts:			
#	27	---	35
\$	2,848,000	---	5,000,000
Continuations:			
#	8	---	5
\$	5,934,000	---	1,000,000
Contracts:			
#	6	---	6
\$	2,553,000	---	2,000,000
Transfers to Other Agencies: 3/			
#	8	---	5
\$	3,626,000	---	2,000,000

1/ Includes \$5,500,000 for Jobs Opportunity for Low Income Families (JOLI) and \$350,000 for State Employment Security Agencies (SESAs).

2/ Support for the Child Welfare Case Management System (SACWIS)

3/ Includes items such as transfers to ASPE for JOBS evaluation, evaluation tap, and data analysis; to National Science Foundation (NSF) for Panel Study of Income Dynamics; and to IRS for tabulations of tax data.

Community Services Block Grant

Authorizing Legislation - Section 672 of the Community Services Block Grant Act, as amended.

<u>1995</u> <u>Enacted</u>	<u>1996 a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$389,600,000	\$389,600,000	\$389,600,000	-0-

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization. Such sums

Purpose and Method of Operations:

The Community Services Block Grant program issues block grants to States, territories, and Indian Tribes to provide services and activities to reduce poverty, including services to address employment, education, better use of available income, housing assistance, nutrition, energy, emergency services, health, and anti-drug needs. Each State submits an annual application and certifies that the State agrees to provide: (1) a range of services and activities having a measurable and potentially major impact on causes of poverty in communities where poverty is an acute problem; and (2) activities designed to assist low-income participants, including the elderly, to become self-sufficient.

Funds are allocated to 50 States and the District of Columbia, Puerto Rico, Guam, American Samoa, the Virgin Islands, the Northern Marianas, the Republic of Palau and State and federally recognized Indian Tribes. Allocations are based on relative percentages of 1981 funding levels under Section 221 of the Economic Opportunity Act of 1964 as amended.

Funding for the Community Services Block Grant over the past five years has been:

FY 1992	\$360,000,000
FY 1993	\$372,000,000
FY 1994	\$397,000,000
FY 1995	\$389,600,000
FY 1996	\$389,600,000

Rationale for the Budget Request:

The FY 1997 request for the Community Services Block Grant is \$389,600,000 the same as FY 1996 policy level. These funds will be used to provide a flexible source of funding for an array of social services and programs that are planned, designed, and implemented at the local level.

Grant funds will be used by a network of local agencies, Community Action Agencies, Federal/State recognized Indian Tribes/Tribal organizations, Migrant and Seasonal Farmworker organizations, or private/public community-based organizations to provide a range of services and activities to assist low-income individuals, including the elderly, to alleviate the causes and conditions of poverty.

Of the funds appropriated, \$2,015,000 will be used to make grants, contracts, or cooperative agreements for training and technical assistance, and planning and evaluation activities related to provisions of the Community Services Block Grant Act, including training and technical assistance to assist local service providers in the development of improved management practices, Community Services Block Grant data collection, and impact evaluations.

Name of Program: Community Services Block Grants

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	\$387,585,000	\$387,585,000	\$387,585,000
Discretionary	---	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	1,850,000	1,850,000	1,850,000
Evaluation	---	---	---
Program Support	---	---	---
Other	165,000 <u>1/</u>	165,000 <u>1/</u>	165,000 <u>1/</u>
TOTAL PROGRAM	\$389,600,000	\$389,600,000	\$389,600,000
Number of Applicants	170	170	170
Number of Grants	141	141	141
New Starts:			
#	140	140	140
\$	389,435,000	389,435,000	389,435,000
Continuations:			
#	1	1	1
\$	10,000	10,000	10,000
Contracts:			
#	4	4	4
\$	155,000	155,000	155,000

1/ CSBG Peer-to-Peer Training & Technical Assistance - \$122,000
 CSBG monitoring and Assessment Task Force - \$43,000.

Emergency Community Services for the Homeless

Authorizing Legislation - Section 754 of Title VII, Subtitle D, of the Stewart B. McKinney Homeless Assistance Act, as amended.

<u>1995</u> <u>Enacted</u>	<u>1996 a/</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$19,752,000	-0-	-0-	-0-

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization..... \$50,000,000

Purpose and Method of Operations:

The Emergency Community Services for the Homeless Program provides grants to States, territories and Indian Tribes to assist families and individuals who are homeless or are about to become homeless.

The funds appropriated for the Emergency Community Services for the Homeless program are distributed to 57 States and territories that receive funds under the Community Services Block Grant program. Funds are allocated using the formula that applies to the Community Services Block Grant program, which takes into account the relative number of persons living in poverty. In addition, the McKinney Act directs that not less than 1.5 percent of appropriated funds are to be set aside for federally-recognized Indian tribes.

Each State and territory is required to submit an annual application describing its proposed use of the funds and certifying that it will comply with certain statutory and regulatory requirements. Federally-recognized Indian tribes that apply for and receive Community Services Block Grant funding for a fiscal year may also receive Emergency Community Services for the Homeless funding.

Funding for the Emergency Community Services for the Homeless program during the last five years has been as follows:

FY 1992	\$25,000,000
FY 1993	\$19,840,000
FY 1994	\$19,840,000
FY 1995	\$19,752,000
FY 1996	-0-

Rationale for the Budget Request:

The FY 1997 request for Community Services for the Homeless is zero. Similar activities can be provided through the Community Services Block Grant and other Federal programs for the homeless.

Name of Program: Community Services for the Homeless

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	\$19,752,000	---	---
Discretionary	---	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$19,752,000	---	---
Number of Applicants	109 <u>1</u> /	---	---
Number of Grants	109 <u>1</u> /	---	---
New Starts:			
#	109	---	---
\$	19,752,000	---	---
Continuations:			
#	---	---	---
\$	---	---	---
Contracts:			
#	---	---	---
\$	---	---	---

1/ State (52), Tribes (52), Territories (5)

Community Services Discretionary Activities

Authorizing Legislation - Section 681(a) of the Community Services Block Grant Act, as amended.

<u>1995 Enacted</u>	<u>1996 a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$38,964,000	\$38,964,000	-0-	-\$38,964,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization:

Discretionary Activities.....Not more than 9% of the amounts appropriated under 672(b) of the Act.

National Youth Sports.....\$15,000,000.

Purpose and Method of Operations:

Community Services Discretionary Grants provide assistance for projects of national and regional significance. Assistance is provided to private, locally-initiated community development corporations which sponsor enterprises providing employment, training, and business development opportunities for low-income residents; to public and private non-profit agencies for activities benefitting migrants and seasonal farm workers; to public and private organizations to carry out programs in rural housing and community facilities development; and to a private, non-profit organization to provide recreational activities for low-income youth.

Rationale for the Budget Request:COMMUNITY ECONOMIC DEVELOPMENT

The FY 1997 request for Community Economic Development is zero. This reflects the concerns of Congress to reduce the number of discretionary grant programs and the Administration's domestic agenda to develop more comprehensive programs which can be replicated throughout the country. This reduction is not intended to take away program benefits from any particular group, but rather to address the budget deficit in a manner which consolidates these small categorical discretionary grant funds into new initiatives which will provide as much and more program benefit to low-income individuals.

NATIONAL YOUTH SPORTS

The FY 1997 request for National Youth Sports is zero. This reflects the concerns of Congress to reduce the number of discretionary grant programs and the Administration's domestic agenda to develop more comprehensive programs which can be replicated throughout the country. This reduction is not intended to take away program benefits from any particular group, but rather to address the budget deficit in a manner which consolidates these small categorical discretionary grant funds into new initiatives which will provide as much and more program benefit to low-income individuals.

RURAL HOUSING & COMMUNITY FACILITIES DEVELOPMENT

The FY 1997 request for Rural Housing & Community Facilities Development is zero. This reflects the concerns of Congress to reduce the number of discretionary grant programs and the Administration's domestic agenda to develop more comprehensive programs which can be replicated throughout the country. This reduction is not intended to take away program benefits from any particular group, but rather to address the budget deficit in a manner which consolidates these small categorical discretionary grant funds into new initiatives which will provide as much and more program benefit to low-income individuals.

MIGRANTS & SEASONAL FARMWORKERS ASSISTANCE

The FY 1997 request for Migrant & Seasonal Farmworkers Assistance is zero. This reflects the concerns of Congress to reduce the number of discretionary grant programs and the Administration's domestic agenda to develop more comprehensive programs which can be replicated throughout the country. This reduction is not intended to take away program benefits from any particular group, but rather to address the budget deficit in a manner which consolidates these small categorical discretionary grant funds into new initiatives which will provide as much and more program benefit to low-income individuals.

TECHNICAL ASSISTANCE

The FY 1997 request for Technical Assistance is zero. Authority to provide technical assistance was provided as a set-aside in the Block Grant in reauthorizing legislation passed last year.

Name of Program: Community Economic Development

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	---	---	---
Discretionary	\$23,693,000	\$23,693,000	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$23,693,000	\$23,693,000	---
Number of Applicants	260	260	---
Number of Grants	62	62	---
New Starts:			
#	62	62	---
\$	23,693,000	23,693,000	---
Continuations:			
#	---	---	---
\$	---	---	---
Contracts:			
#	---	---	---
\$	---	---	---

Name of Program: National Youth Sports

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	---	---	---
Discretionary	\$12,000,000	\$12,000,000	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$12,000,000	\$12,000,000	---
Number of Applicants	3	3	---
Number of Grants	1	1	---
New Starts:			
#	1	1	---
\$	12,000,000	12,000,000	---
Continuations:			
#	---	---	---
\$	---	---	---
Contracts:			
#	---	---	---
\$	---	---	---

Name of Program: Rural Community Facilities

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	\$3,271,000	\$3,271,000	---
Discretionary	---	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$3,271,000	\$3,271,000	---
Number of Applicants	9	9	---
Number of Grants	7	7	---
New Starts:			
#	7	7	---
\$	3,271,000	3,271,000	---
Continuations:			
#	---	---	---
\$	---	---	---
Contracts:			
#	---	---	---
\$	---	---	---

Demonstration Partnership Program

Authorizing Legislation - Section 408 of the Human Services Reauthorization Act of 1986, as amended.

<u>1995 Enacted</u>	<u>1996 a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$640,000	-0-	-0-	-0-

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Such sums.

Purpose and Method of Operations:

The Demonstration Partnership Program provides grants to entities eligible for funding under the Community Services Block Grant -- primarily community action agencies -- to develop, in partnership with other public and private organizations, unique and innovative approaches to reduce dependency of the poor on public assistance programs. Funds must be matched by recipients on a 50-50 basis, with no individual grant to exceed \$350,000. The Department is required to disseminate the results of successful projects for replication throughout the country.

Funding for the Demonstration Partnership Program during the last five years has been as follows:

FY 1992	\$4,050,000
FY 1993	\$3,804,000
FY 1994	\$7,995,000
FY 1995	\$ 640,000
FY 1996	-0-

Rationale for the Budget Request:

The FY 1997 request for Demonstration Partnership Program is zero. This reflects the concerns of Congress to reduce the number of discretionary grant programs and the Administration's domestic agenda to develop more comprehensive programs which can be replicated throughout the country. This reduction is not intended to take away program benefits from any particular group, but rather to address the budget deficit in a manner which consolidates these small categorical discretionary grant funds into new initiatives which will provide as much and more program benefit to low-income individuals.

Name of Program: Community Demonstration Partnership

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	---	---	---
Discretionary	\$575,000	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	\$65,000 <u>1/</u>	---	---
Other	---	---	---
TOTAL PROGRAM	\$640,000 <u>2/</u>	---	---
Number of Applicants	96	---	---
Number of Grants	---	---	---
New Starts:			
#	---	---	---
\$	---	---	---
Continuations:			
#	2	---	---
\$	575,000	---	---
Contracts:			
#	6	---	---
\$	65,000	---	---

1/ Two percent for planning and technical assistance

2/ Public Law 104-14 further reduces the FY appropriation.

Community Food and Nutrition

Authorizing Legislation - Section 681A.(d) of the Community Services Block Grant Act, as amended.

<u>1995 Enacted</u>	<u>1996 a/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$8,676,000	-0-	-0-	-0-

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

1997 Authorization.....Such sums.

Purpose and Method of Operations:

The Community Food and Nutrition program provides grants to public and private agencies at the local and State level to: (1) coordinate existing food assistance resources; (2) assist in identifying sponsors of child nutrition programs and initiating new programs in under served and unserved areas; and (3) develop innovative approaches at the State and local level to meet the nutrition needs of low-income people.

The authorizing legislation mandates that 60 percent of the amount appropriated, up to \$6,000,000, is to be allotted to States for statewide programs and 40 percent is to be awarded on a competitive basis. Amounts appropriated in excess of \$6,000,000 are allotted as follows: (1) 40 percent of such excess is to be allotted to eligible agencies for statewide grants; (2) 40 percent of such excess is to be awarded on a competitive basis for local and statewide programs; and (3) 20 percent of such excess is to be awarded on a competitive basis for nationwide programs, including programs benefitting Native Americans and migrant farm workers.

The projects must focus on one or more of the legislatively-mandated program activities: (1) coordination of existing private and public food assistance resources, whenever such coordination is determined to be inadequate in serving the needs of low-income people; (2) assistance to low-income communities in identifying potential sponsors of child nutrition programs and initiating new programs in underserved or unserved areas; and (3) development of innovative approaches at the national, state or local levels to meet the nutrition needs of low-income people.

Funding for the Community Food and Nutrition program during the last five years has been as follows:

FY 1992	\$7,000,000
FY 1993	\$6,944,000
FY 1994	\$7,995,000
FY 1995	\$8,676,000
FY 1996	-0-

Rationale for the Budget Request:

The FY 1997 request for Community Food & Nutrition is zero. This reflects the concerns of Congress to reduce the number of small discretionary grant programs and maintain flexibility for the Secretary to continue key initiatives of national significance. This reduction is not intended to take away program benefits from any particular group, but rather to address the budget deficit in a manner which consolidates these small categorical discretionary grant funds into new initiatives which will provide as much and more program benefit to low-income individuals.

Name of Program: Community Food & Nutrition

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	\$4,670,400	---	---
Discretionary	\$4,005,600	---	---
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$8,676,000	---	---
Number of Applicants	180 <u>1</u> /	---	---
Number of Grants	130 <u>2</u> /	---	---
New Starts:			
#	130	---	---
\$	8,676,000	---	---
Continuations:			
#	---	---	---
\$	---	---	---
Contracts:			
#	---	---	---
\$	---	---	---
<u>1/</u> State Applicants (52), Grantees (128)			
<u>2/</u> State Applicants (52), Grantees (78)			

Federal Administration

	1995 <u>Actual</u>	1996 <u>Policy/</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Amount	\$162,299,000	\$150,933,000	\$160,279,000	+\$9,346,000
FTE Ceiling	1,983*	1,803**	1,803	--
FTE usage	1,803*	1,759	1,768	+9

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

*/ Does not include the effect of devolving approximately 23 FTE from the Office of the Secretary to ACF in connection with the decentralization of personnel servicing operations.

**/ Reflects a reduction, as of February, 1996, from an original FTE ceiling of 2,009 to the current ceiling of 1,803 FTE.

Purpose and Method of Operation

Salaries and related expenses of administering the Administration for Children and Families (ACF) are included in the Federal Administration activity. ACF conducts its operations at the following locations:

- ACF Headquarters, Washington, D.C.;
- Each of the regional offices of the Department of Health and Human Services (HHS);
- Social Security Administration facilities at Baltimore, Maryland, where ACF staff run the Federal Parent Locator Service for the Child Support Enforcement program and other ADP systems used to administer ACF programs; and,
- Thirteen audit offices of the Office of Child Support Enforcement in various locations throughout the Nation.

Approximately one-half of the ACF employees work at ACF Headquarters in the various program offices and staff offices. The other half of ACF's work force is in regional and field offices.

Rationale for the Budget Request:

The FY 1997 budget request for Federal Administration of \$160,279,000 is a net increase of \$9,346,000 (+6%) over the funding level assumed under the FY 1996 policy level. This request will allow ACF to maintain the staff and related essential programmatic support activities which are necessary if ACF is to continue the President's important children and family initiatives.

These initiatives include:

- Head Start, where staff are working both to expand the number of children who can be served by the Head Start program, and to continue the emphasis begun in recent years to improve the quality of services provided under this program;
- Child Care, where staff will work to expand services to more low-income families and to assist States to improve service quality;
- Child Welfare, where efforts will be maintained to shape a continuum of services which better serve children at risk and allow them to remain together with their families; and,
- Welfare Reform, where the President has urged a bipartisan effort to enact legislation, including major new responsibilities envisioned in the area of Child Support Enforcement.

The FY 1997 request allows for modest staff increases (+9 FTE) to offset staff reductions of recent years. By making these small increases, and by continuing to invest in information systems and other technologies which produce greater productivity from its shrinking workforce, ACF will be able to maintain the initiatives which are key to its mission. These increases will not, however, change ACF's commitment to carefully manage its Federal Administration resources.

Over the last two years, ACF has moved to downsize, streamline and consolidate its personnel and related activities. Its FTE ceiling for FY 1996 has been reduced from 2,009, established in FY 1995, to its current ceiling of 1,803 FTE. ACF has also aggressively moved to reduce actual FTE usage, which has dropped from 1,965 in FY 1994 to the current estimate for FY 1996 of 1,759 FTE. Further, the 1,759 FTE is expected to be achieved despite the devolution to ACF of 23 FTE from the Office of the Secretary in connection with the decentralization of personnel servicing operations.

In FY 1997, projected FTE usage of 1,768 will again remain under ACF's ceiling of 1,803. The additional \$9.3 million requested for Federal Administration in FY 1997 will support ACF's full-time equivalent positions and related expenses, including built-in increases for annualization of the 1996 locality and pay raises and within-grade increases. ACF also needs this increase to continue its effort to invest in information systems and related technology which have to date allowed its diminished workforce to handle workload demands which continue in the aggregate to grow.

Finally, these additional funds requested for FY 1997 will also allow ACF to cover increases in the costs of mandatory non-pay activities; without these funds ACF's ability to provide effective, efficient stewardship of the \$33.8 billion in Federal funds entrusted to it for FY 1997 will be jeopardized. Thus a portion of the increase will be provided for higher core costs including rent, telecommunications, and contractual obligations. Extensive efforts will continue to contain these costs, since increases limit funds available for other key functions such as travel to monitor implementation of ACF programs, training and technical assistance.

Federal Administration
SUMMARY OF CHANGES

1996 Policy.....	\$150,933,000
1997 Estimate.....	<u>160,279,000</u>
Net Change.....	+9,346,000

	<u>1996 Base</u>	<u>Change From Base</u>
--	------------------	-----------------------------

INCREASES:

A. BUILT-IN:

1. Annualization of January 1995 pay raise, within grade increases, and January 1996 pay raise..	\$97,168,000	+\$4,629,000
2. Related Personnel benefits.....	17,405,000	+710,000
3. Benefits from former personnel.....	500,000	+11,000
4. Transportation of things	67,000	+1,000
5. Rental Payments to GSA..	13,436,000	+295,000
6. Rental Payments, other...	7,000	---
7. Communications/Utilities/Miscellaneous	2,247,000	+49,000
Subtotal Increases....	\$130,830,000	+\$5,695,000

B. PROGRAM:

1. Travel for Technical Assistance and Monitoring.....	1,721,000	+1,269,000
2. Consulting Services.....	35,000	+1,000
3. Other Services (includes ADP).....	5,043,000	+1,098,000
4. Supplies and materials..	638,000	+14,000
5. Equipment/Consolidation.	459,000	+998,000

6. Purchases of goods and services for government accounts...	10,060,000	+224,000
7. Printing and reproduction....	901,000	+20,000
8. Operation and maintenance of equipment.....	1,136,000	+25,000
9. Insurance Indemnities	110,000	+2,000
Subtotal Program Increases.....	\$20,103,000	+\$3,651,000
Total INCREASES.....	\$150,933,000	+\$9,346,000

ADMINISTRATION FOR CHILDREN AND FAMILIES

Administrative Costs
(Federal Administration)

	1996 <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Travel (21.0).....	\$1,721,000	\$2,990,000	+\$1,269,000
Transportation of Things (22.0).....	67,000	68,000	+1,000
Communications, Utilities & Miscellaneous charges (23.3).....	2,247,000	2,296,000	+49,000
Printing & Reproduction (24.0)...	901,000	921,000	20,000
Consulting Services (25.1).....	35,000	36,000	+1,000
Other Services (25.2)...	5,043,000	6,141,000	+1,098,000
Purchases of goods & services for government account (25.3).....	10,060,000	10,284,000	+224,000
Supplies & Materials (26.0).....	<u>638,000</u>	<u>652,000</u>	<u>+14,000</u>
 TOTAL	 \$20,712,000	 \$23,388,000	 +\$2,676,000

Exhibit O

Detail of Full-Time Equivalent Employment (FTE)

	1995 <u>Actual</u>	1996 Current <u>Estimate</u>	1997 <u>Estimate</u>
Administration for Children, Youth and Families.....	175	181	184
Office of Program Support.....	*	177	177
Office of Child Support Enforcement.....	147	154	157
Office of Family Assistance...	101	89	89
Office of Community Services..	60	60	60
Office of Regional Operations/ State Systems.....	*	46	46
Office of Refugee Resettlement	38	34	34
Administration for Developmental Disabilities..	32	32	32
Office of Human Resource Management.....	*	28	28
Administration for Native Americans.....	26	24	24
Office of Public Affairs.....	*	23	23
Office of Planning, Research and Evaluation.....	*	18	18
Immediate Office of the Assistant Secretary.....	*	17	17
Office of Legislative Affairs and Budget.....	*	15	15
Executive Secretariat.....	*	13	13
Office of Staff Development & Organizational Resources....	*	12	12
President's Committee on Mental Retardation.....	*	11	11
EEO/Civil Rights, Spec.			

Initiatives.....	*	8	8
Advisory Board on Child Abuse and Neglect.....	*	4	0
Other.....	381*	--	--
Regional Offices.....	<u>843</u>	<u>813</u>	<u>820</u>
Total, ACF.....	1,803	1,759**	1,768**

Average GS Grade

1993.....	11.4
1994.....	11.6
1995.....	11.6
1996.....	11.7
1997.....	11.6

* Due to reorganizations in FY 1995 in Central Office staff offices, comparable numbers by staff office are not available.

** Reflects estimated usage based on availability of funds; FTE ceiling for ACF remains at 1,803 in FY 1996 and FY 1997.

Exhibit P

Program Administration
Detail of Positions

	1995 <u>Actual</u>	1996 <u>Estimate</u>	1997 <u>Estimate</u>
Executive Level I.....	0	0	0
Executive Level II.....	0	0	0
Executive Level III.....	0	0	0
Executive Level IV.....	1	1	1
Executive Level V.....	<u>2</u>	<u>2</u>	<u>2</u>
Subtotal.....	3	3	3
Total - Exec. Lev. Salary...	\$330,970	\$330,970	\$330,970
ES-6.....	0	0	0
ES-5.....	1	0	0
ES-4.....	5	6	6
ES-3.....	5	5	4
ES-2.....	2	2	2
ES-1.....	<u>7</u>	<u>11</u>	<u>12</u>
Subtotal.....	20	24	24
Total - ES Salary.....	\$2,002,400	\$2,522,879	\$2,603,096
GS-15.....	100	97	97
GS-14.....	208	201	201
GS-13.....	592	583	585
GS-12.....	364	371	371
GS-11.....	103	109	104
GS-10.....	1	1	1
GS-9.....	89	82	83
GS-8.....	20	22	20
GS-7.....	84	81	82
GS-6.....	93	93	93
GS-5.....	49	40	46
GS-4.....	14	9	13
GS-3.....	4	5	4
GS-2.....	6	2	5
GS-1.....	<u>3</u>	<u>2</u>	<u>3</u>
Subtotal.....	1,730	1,698 <u>3/</u>	1,709
Ungraded.....	1	1	1
Total, full-time permanent filled positions, end-of-year.....	1,754	1,726	1,737
Part-time/other positions.....	43	43	43
Total, filled positions <u>1/</u>	1,797	1,769	1,780
Unfilled positions, end-of- year.....	186	56	45
Total positions, end-of-year..	1,983 <u>2/</u>	1,825	1,825

FTE ceiling.....	1,983	1,803	1,803
Full-time equivalent usage....	1,803	1,759	1,768

Average ES level.....	2.6	2.3	2.2
Average ES salary.....	\$100,120	\$105,120	\$108,462
Average GS grade.....	11.6	11.7	11.6
Average GS salary.....	\$53,809	\$55,532	\$57,225
Special Pay:			
Average Wage Grade level....	5.5	5.5	5.5
Average Wage Grade salary...	\$27,598	\$28,299	\$29,148

1/ Excludes 48 advisory board members.

2/ Does not include 23 positions transferred to ACF from the Office of the Secretary (OS) beginning in FY 1996, due to creation of ACF's servicing personnel office.

3/ Includes the accession of 23 positions transferred to ACF from the Office of the Secretary (OS) on 10-1-1996 as part of the creation of ACF's servicing personnel office.

Exhibit H

Federal Administration
Budget Authority by Object

	1996 <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Full-time equivalent employment...	1,759	1,768	+9
Full-time equivalent of overtime and holiday hours.....	2	3	+1
Average SES salary.....	\$106,055	\$109,601	+\$3,546
Average GS grade.....	11.6	11.6	--
Average GS salary.....	\$55,532	\$57,225	+\$1,693
Average wage grade salary.....	\$28,299	\$29,148	+\$849
Average salary of ungraded positions 1/.....	\$17,768	\$18,301	+\$533
Personnel compensation:			
Full-time permanent	95,748	99,790	+\$4,042
Other than full time permanent	1,370	1,427	+57
Other personnel compensation	50	580	+530
Total, personnel compensation	97,168	101,797	+4,629
Personnel benefits	500,000	511,000	+11,000
Benefits for former personnel	17,405,000	18,115,000	+710,000
Travel and transportation of persons	1,721,000	2,990,000	+1,269,000
Transportation of things	67,000	68,000	+1,000
Rental payments to GSA	13,436,000	13,731,000	+295,000
Communications, utilities and misc.	2,247,000	2,296,000	+49,000
Printing and reproduction	901,000	921,000	+20,000
Consulting Services	35,000	36,000	+1,000
Other Services	5,043,000	6,141,000	+1,098,000
Purchases of goods and services	10,060,000	10,284,000	+224,000

Federal Administration
Budget Authority by Object
(Continued)

	1996 <u>Policy</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Operation and maintenance of equipment	1,136,000	1,161,000	+25,000
Supplies and materials	638,000	652,000	+14,000
Equipment	459,000	1,457,000	+998,000
Grants, Subsidies and Contributions	---	---	---
Indemnities	<u>110,000</u>	<u>112,000</u>	<u>+2,000</u>
 TOTAL BUDGET AUTHORITY BY OBJECT	 \$150,933,000	 \$160,279,000	 +\$9,346,000

1/ Only includes stay-in-school participants (4); excludes experts and consultants (8) and advisory board and commission members (48).

State Tables

HEAD START

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
Alabama	\$57,542,124	\$59,081,934	\$64,190,527
Alaska	6,534,015	6,717,790	7,375,983
Arizona	47,208,654	48,613,467	54,042,960
Arkansas	32,681,332	33,580,022	36,692,751
California	392,327,279	403,922,975	448,353,554
Colorado	35,757,419	36,731,232	40,054,130
Connecticut	27,022,399	27,778,173	30,463,015
Delaware	6,027,444	6,191,050	6,746,410
Dist. of Columbia	14,328,962	14,690,507	15,771,066
Florida	125,508,329	129,242,693	143,673,507
Georgia	85,792,487	88,244,253	97,225,749
Hawaii	10,311,724	10,599,664	11,620,153
Idaho	10,009,494	10,294,570	11,333,925
Illinois	148,119,528	152,195,536	166,328,836
Indiana	48,871,396	50,283,497	55,535,059
Iowa	25,538,981	26,263,206	28,887,629
Kansas	24,772,457	25,456,906	27,844,720
Kentucky	58,383,338	59,962,860	65,296,637
Louisiana	78,691,240	80,933,816	89,117,198
Maine	13,118,360	13,472,370	14,662,968
Maryland	42,022,792	43,175,760	47,155,479
Massachusetts	61,128,903	62,767,507	68,219,136
Michigan	132,989,827	136,710,829	149,937,184
Minnesota	38,280,795	39,387,494	43,506,323
Mississippi	95,492,812	97,666,266	102,802,503
Missouri	58,751,659	60,417,824	66,456,176
Montana	9,772,387	10,052,844	11,086,257
Nebraska	15,455,520	15,879,817	17,345,681
Nevada	8,315,481	8,572,190	9,609,598
New Hampshire	6,378,639	6,553,993	7,161,089

HEAD START

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
New Jersey	74,610,063	76,526,409	82,448,580
New Mexico	27,268,521	28,046,146	30,886,403
New York	226,840,468	233,240,306	256,271,536
North Carolina	71,602,790	73,617,691	80,839,350
North Dakota	6,965,925	7,154,505	7,791,967
Ohio	139,497,114	143,419,947	157,466,381
Oklahoma	40,704,612	41,848,137	45,936,846
Oregon	29,086,414	29,904,829	32,837,737
Pennsylvania	126,251,324	129,743,326	141,945,502
Puerto Rico	132,422,586	136,082,752	148,859,256
Rhode Island	10,453,320	10,747,601	11,802,987
South Carolina	44,021,172	45,244,464	49,549,016
South Dakota	8,257,835	8,493,609	9,356,208
Tennessee	61,630,199	63,405,518	69,980,515
Texas	223,309,411	229,937,902	255,467,286
Utah	18,144,897	18,655,338	20,484,010
Vermont	7,636,277	7,819,901	8,316,552
Virginia	48,895,701	50,276,168	55,247,396
Washington	53,385,264	54,893,707	60,332,092
West Virginia	27,625,686	28,387,829	31,040,699
Wisconsin	52,632,689	54,080,469	59,097,452
Wyoming	5,099,055	5,238,011	5,712,637
Outer Pacific	9,308,716	9,571,000	10,508,867
Virgin Islands	6,228,263	6,403,000	7,031,259
Indian	95,178,000	97,856,000	107,409,000
Migrant	138,754,000	142,645,000	156,564,000
Discretionary	131,183,000	132,320,000	139,348,000
Total, Budget Authority	\$3,534,129,000	\$3,631,000,000	\$3,981,028,000

Family Violence and Prevention Services

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Alabama	\$ 351,758	\$ 351,758	\$ 351,758
Alaska	200,000	200,000	200,000
Arizona	330,671	330,671	330,671
Arkansas	203,645	203,645	203,645
California	2,622,120	2,622,120	2,622,120
Colorado	299,587	299,587	299,587
Connecticut	275,307	275,307	275,307
Delaware	200,000	200,000	200,000
D.C.	200,000	200,000	200,000
Florida	1,149,202	1,149,202	1,149,202
Georgia	581,112	581,112	581,112
Hawaii	200,000	200,000	200,000
Idaho	200,000	200,000	200,000
Illinois	982,690	982,690	982,690
Indiana	479,961	479,961	479,961
Iowa	236,410	236,410	236,410
Kansas	212,634	212,634	212,634
Kentucky	318,322	318,322	318,322
Louisiana	360,832	360,832	360,832
Maine	200,000	200,000	200,000
Maryland	417,120	417,120	417,120
Mass.	505,081	505,081	505,081
Michigan	796,267	796,267	796,267
Minnesota	379,483	379,483	379,483
Mississippi	222,044	222,044	222,044
Missouri	439,719	439,719	439,719
Montana	200,000	200,000	200,000
Nebraska	200,000	200,000	200,000
Nevada	200,000	200,000	200,000
New Hampshire	200,000	200,000	200,000

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
New Jersey	661,931	661,931	661,931
New Mexico	200,000	200,000	200,000
New York	1,528,769	1,528,769	1,528,769
North Carolina	583,464	583,464	583,464
North Dakota	200,000	200,000	200,000
Ohio	931,779	931,779	931,779
Oklahoma	271,443	271,443	271,443
Oregon	254,724	254,724	254,724
Pennsylvania	1,011,506	1,011,506	1,011,506
Puerto Rico	300,763	300,763	300,763
Rhode Island	200,000	200,000	200,000
South Carolina	306,056	306,056	306,056
South Dakota	200,000	200,000	200,000
Tennessee	428,378	428,378	428,378
Texas	1,514,823	1,514,823	1,514,823
Utah	200,000	200,000	200,000
Vermont	200,000	200,000	200,000
Virginia	545,323	545,323	545,323
Washington	441,483	441,483	441,483
West Virginia	200,000	200,000	200,000
Wisconsin	423,253	423,253	423,253
Wyoming	200,000	200,000	200,000
Territories	150,740	150,740	150,740
Total	\$24,118,400	\$24,118,400	\$24,118,400

1/ Excludes discretionary activities and State Domestic Violence grants.

COMPREHENSIVE RUNAWAY AND HOMELESS YOUTH

<u>STATE</u>	<u>1995 ENACTED</u>	<u>1996 POLICY</u>	<u>1997 REQUEST</u>
Alabama			993,588
Alaska			166,990
American Samoa			45,000
Arizona			936,997
Arkansas			580,753
California			7,572,052
Colorado			819,177
Connecticut			715,272
Delaware			155,857
District/Columbia			112,254
Florida			2,780,378
Georgia			1,646,704
Guam			45,000
Hawaii			268,111
Idaho			295,943
Illinois			2,780,378
Indiana			1,359,110
Iowa			673,525
Kansas			623,428
Kentucky			889,684
Louisiana			1,143,879
Maine			283,882
Marshall Islands			
Maryland			1,114,192
Massachusetts			1,274,688
Michigan			2,304,457
Minnesota			1,103,059
Mississippi			696,718
Missouri			1,243,145
Montana			206,882
Nebraska			403,558
Nevada			298,726
New Hampshire			259,762

COMPREHENSIVE RUNAWAY AND HOMELESS YOUTH (CONTINUED)

<u>STATE</u>	<u>1995 ENACTED</u>	<u>1996 POLICY</u>	<u>1997 REQUEST</u>
New Jersey			1,708,861
New Mexico			424,896
New York			4,050,427
North Carolina			1,524,244
North Dakota			160,496
Ohio			2,615,244
Oklahoma			783,924
Oregon			693,935
Pennsylvania			2,624,521
Puerto Rico			1,070,589
Rhode Island			213,376
South Carolina			870,202
South Dakota			186,472
Tennessee			1,141,096
Texas			4,609,842
Utah			596,524
Vermont			134,519
Virgin Islands			45,000
Virginia			1,426,834
Washington			1,219,024
West Virginia			405,414
Wisconsin			1,216,241
Wyoming			126,170
Discretionary			6,931,180
Total, Budget Authority			\$68,572,180

RUNAWAY AND HOMELESS YOUTH PROGRAM

<u>STATE</u>	<u>1995 ENACTED</u>	<u>1996 POLICY</u>	<u>1997 REQUEST</u>
Alabama	569,027	555,502	
Alaska	100,000	100,000	
American Samoa	45,000	45,000	
Arizona	565,329	585,849	
Arkansas	335,499	329,186	
California	4,540,592	5,185,888	
Colorado	5,587	498,923	
Connecticut	406,467	406,311	
Delaware	100,000	100,000	
District of Columbia	100,000	100,000	
Florida	1,674,324	2,000,000	
Georgia	972,682	1,000,000	
Guam	45,000	45,000	
Hawaii	157,975	156,364	
Idaho	175,939	174,366	
Illinois	1,620,961	1,700,000	
Indiana	776,138	757,643	
Iowa	387,805	353,918	
Kansas	361,388	374,964	
Kentucky	513,022	498,923	
Louisiana	656,732	635,227	
Maine	162,202	158,392	
Marshall Islands	--	--	
Maryland	655,675	700,000	
Massachusetts	735,984	735,440	
Michigan	1,324,031	1,525,743	
Minnesota	648,807	638,313	
Mississippi	400,485	388,851	
Missouri	720,133	709,294	
Montana	122,576	122,416	
Nebraska	231,943	227,344	
Nevada	185,977	193,397	
New Hampshire	149,521	157,191	

RUNAWAY AND HOMELESS YOUTH PROGRAM (continued)

<u>STATE</u>	1995 <u>ENACTED</u>	1996 <u>POLICY</u>	1997 <u>REQUEST</u>
New Jersey	1,001,741	1,250,000	
New Mexico	254,134	256,148	
New York	2,360,643	2,550,000	
North Carolina	900,299	1,125,000	
North Dakota	100,000	100,000	
Northern Marianas	45,000	45,000	
Ohio	1,510,537	1,792,966	
Oklahoma	459,131	452,631	
Oregon	413,165	402,739	
Palau	45,000	--	
Pennsylvania	1,517,405	1,750,000	
Puerto Rico	609,709	825,000	
Rhode Island	124,161	124,445	
South Carolina	502,984	489,665	
South Dakota	109,896	106,986	
Tennessee	670,469	667,117	
Texas	2,738,409	3,000,000	
Utah	351,349	345,646	
Vermont	100,000	100,000	
Virgin Islands	45,000	45,000	
Virginia	839,011	824,509	
Washington	735,984	724,210	
West Virginia	229,301	220,658	
Wisconsin	709,038	692,835	
Wyoming	100,000	100,000	
Discretionary	4,048,797	4,350,000	
Total, Budget Authority	\$40,457,964	\$43,500,000	

CHILD ABUSE STATE GRANTS

<u>STATE</u>	<u>1995 ENACTED</u>	<u>1996 POLICY</u>	<u>1997 REQUEST</u>
Alabama	394,144	363,146	363,146
Alaska	122,760	118,004	118,004
Arizona	392,006	379,434	379,434
Arkansas	259,064	241,679	241,679
California	2,691,125	2,460,107	2,460,107
Colorado	351,665	332,780	332,780
Connecticut	301,850	282,537	282,537
Delaware	117,354	113,311	113,311
Dist. of Columbia	100,151	97,851	97,851
Florida	1,033,486	965,236	965,236
Georgia	627,633	587,584	587,584
Hawaii	156,377	148,923	148,923
Idaho	166,768	158,585	158,585
Illinois	1,002,618	915,821	915,821
Indiana	61,014	471,638	471,638
Iowa	289,319	266,249	266,249
Kansas	274,039	255,482	255,482
Kentucky	347,515	332,780	332,780
Louisiana	444,877	405,935	405,935
Maine	158,822	149,475	149,475
Maryland	444,265	413,665	413,665
Massachusetts	490,718	458,112	458,112
Michigan	830,864	762,056	762,056
Minnesota	440,293	407,592	407,592
Mississippi	296,655	273,702	273,702
Missouri	481,549	445,688	445,688
Montana	135,903	130,703	130,703
Nebraska	199,164	187,019	187,019
Nevada	172,575	168,799	168,799
New Hampshire	151,488	145,610	145,610

CHILD ABUSE STATE GRANTS (CONTINUED)

<u>STATE</u>	<u>1995 ENACTED</u>	<u>1996 POLICY</u>	<u>1997 REQUEST</u>
New Jersey	644,440	598,075	598,075
New Mexico	211,998	202,479	202,479
New York	1,430,478	1,310,037	1,310,037
North Carolina	184,339	549,763	549,763
North Dakota	117,566	112,483	112,483
Ohio	938,745	852,879	852,879
Oklahoma	330,576	307,934	307,934
Oregon	303,990	281,156	281,156
Pennsylvania	104,960	865,026	865,026
Rhode Island	136,818	131,255	131,255
South Carolina	355,944	327,810	327,810
South Dakota	128,567	122,421	122,421
Tennessee	452,822	423,052	423,052
Texas	1,618,055	1,528,126	1,528,126
Utah	268,232	250,514	250,514
Vermont	109,009	105,305	105,305
Virginia	550,313	507,526	507,526
Washington	490,718	453,694	453,694
West Virginia	197,637	183,430	183,430
Wisconsin	475,132	436,855	436,855
Wyoming	107,175	102,821	102,821
Puerto Rico	400,191	402,071	402,071
Virgin Islands	75,346	75,214	75,214
American Samoa	71,152	71,073	71,073
Guam	78,702	78,527	78,527
Trust Territory (Palau)	66,678	66,658	66,658
Northern Marianas	68,356	68,313	68,313
Total, Budget Authority	\$22,854,000 ¹	\$22,854,000 ²	\$22,854,000

¹ Actual includes amounts redistributed from States that had not obligated their funds within 18 months.

² Estimates based on the assumption that all States will be eligible.

COMMUNITY-BASED FAMILY RESOURCE PROGRAM

<u>STATE</u>	1995 <u>ENACTED</u>	1996 <u>POLICY 1/</u>	1997 <u>REQUEST 1/</u>
Alabama	640,525		
Alaska	121,485		
Arizona	437,465		
Arkansas	313,789		
California	1,794,504		
Colorado	369,993		
Connecticut	259,494		
Delaware	143,033		
Dist. of Columbia	117,803		
Florida	460,243		
Georgia	1,027,351		
Hawaii	133,990		
Idaho	158,340		
Illinois	524,459		
Indiana	392,398		
Iowa	183,439		
Kansas	436,799		
Kentucky	269,113		
Louisiana	347,356		
Maine	227,521		
Maryland	2,222,122		
Massachusetts	840,333		
Michigan	852,271		
Minnesota	598,985		
Mississippi	251,239		
Missouri	859,997		
Montana	150,629		
Nebraska	259,998		
Nevada	280,507		
New Hampshire	203,489		

1/ Impossible to estimate future amounts because awards are based on federal match of claims submitted by the states.

COMMUNITY-BASED FAMILY RESOURCE PROGRAM (CONTINUED)

<u>STATE</u>	1995 <u>ENACTED</u>	1996 <u>POLICY 1/</u>	1997 <u>REQUEST 1/</u>
New Jersey	726,160		
New Mexico	154,679		
New York	878,275		
North Carolina	293,706		
North Dakota	165,703		
Ohio	1,429,613		
Oklahoma	674,146		
Oregon	188,896		
Pennsylvania	932,457		
Rhode Island	154,846		
South Carolina	424,980		
South Dakota	168,305		
Tennessee	244,257		
Texas	1,880,703		
Utah	239,197		
Vermont	184,756		
Virginia	311,345		
Washington	493,534		
West Virginia	418,083		
Wisconsin	934,889		
Wyoming	185,800		
American Samoa	100,000		
Virgin Islands	100,000		
Guam	100,000		
Trust Territory (Palau)	100,000		
Northern Mariana	100,000		
American Indian Programs	N/A		
Migrant Programs	N/A		
Special Projects	N/A		
Discretionary Grants	4,900,000		
Total, Budget Authority	\$31,363,000	\$0	\$0

1/ Impossible to estimate future amounts because awards are based on federal match of claims submitted by the States

CHILD WELFARE SERVICES

STATE	1995 <u>ENACTED</u>	1996 <u>POLICY</u>	1997 <u>REQUEST</u>
Alabama	\$5,511,953	\$5,511,953	\$5,511,953
Alaska	756,386	756,386	756,386
Arizona	5,036,395	5,036,395	5,036,395
Arkansas	3,386,737	3,386,737	3,386,737
California	31,577,979	31,577,979	31,577,979
Colorado	3,903,679	3,903,679	3,903,679
Connecticut	2,076,549	2,076,549	2,076,549
Delaware	720,092	720,092	720,092
Dist. of Columbia	426,908	426,908	426,908
Florida	13,095,674	13,095,674	13,095,674
Georgia	8,417,800	8,417,800	8,417,800
Hawaii	1,204,766	1,204,766	1,204,766
Idaho	1,718,872	1,718,872	1,718,872
Illinois	11,634,207	11,634,207	11,634,207
Indiana	6,832,308	6,832,308	6,832,308
Iowa	3,401,783	3,401,783	3,401,783
Kansas	3,033,606	3,033,606	3,033,606
Kentucky	4,960,940	4,960,940	4,960,940
Louisiana	6,411,669	6,411,669	6,411,669
Maine	1,455,298	1,455,298	1,455,298
Maryland	4,291,240	4,291,240	4,291,240
Massachusetts	4,596,904	4,596,904	4,596,904
Michigan	10,634,338	10,634,338	10,634,338
Minnesota	5,070,373	5,070,373	5,070,373
Mississippi	4,244,902	4,244,902	4,244,902
Missouri	6,071,611	6,071,611	6,071,611
Montana	1,219,514	1,219,514	1,219,514
Nebraska	2,032,223	2,032,223	2,032,223
Nevada	1,429,605	1,429,605	1,429,605
New Hampshire	1,073,714	1,073,714	1,073,714

CHILD WELFARE SERVICES (continued)

STATE	1995 <u>ENACTED</u>	1996 <u>POLICY</u>	1997 <u>REQUEST</u>
New Jersey	5,193,337	5,193,337	5,193,337
New Mexico	2,525,815	2,525,815	2,525,815
New York	15,231,175	15,231,175	15,231,175
North Carolina	8,085,827	8,085,827	8,085,827
North Dakota	928,706	928,706	928,706
Ohio	12,747,566	12,747,566	12,747,566
Oklahoma	4,373,829	4,373,829	4,373,829
Oregon	3,555,161	3,555,161	3,555,161
Pennsylvania	11,949,139	11,949,139	11,949,139
Rhode Island	1,031,739	1,031,739	1,031,739
South Carolina	4,866,961	4,866,961	4,866,961
South Dakota	1,077,153	1,077,153	1,077,153
Tennessee	6,166,027	6,166,027	6,166,027
Texas	23,796,313	23,796,313	23,796,313
Utah	3,480,561	3,480,561	3,480,561
Vermont	699,111	699,111	699,111
Virginia	6,322,824	6,322,824	6,322,824
Washington	5,740,698	5,740,698	5,740,698
West Virginia	2,417,214	2,417,214	2,417,214
Wisconsin	5,949,970	5,949,970	5,949,970
Wyoming	719,171	719,171	719,171
American Samoa	190,319	190,319	190,319
Guam	345,731	345,731	345,731
Northern Mariana	140,186	140,186	140,186
Puerto Rico	7,950,897	7,950,897	7,950,897
Virgin Islands	275,545	275,545	275,545
Total, Budget Authority	\$291,989,000	\$291,989,000	\$291,989,000

DEVELOPMENTAL DISABILITIES PROTECTION AND ADVOCACY PROGRAM

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Alabama	447,608	443,606	439,048
Alaska	257,010	254,508	254,508
Arizona	339,251	339,119	344,561
Arkansas	261,105	257,788	258,072
California	2,171,143	2,180,763	2,211,563
Colorado	274,667	274,211	276,741
Connecticut	261,153	259,173	260,970
Delaware	257,010	254,508	254,508
D.C.	254,508	254,508	254,508
Florida	1,062,105	1,056,678	1,070,357
Georgia	600,134	601,121	603,004
Hawaii	257,010	254,508	254,508
Idaho	257,010	254,508	254,508
Illinois	920,606	912,328	906,534
Indiana	516,832	514,368	506,712
Iowa	268,955	265,501	264,834
Kansas	257,010	254,508	254,508
Kentucky	409,921	405,062	405,708
Louisiana	472,485	466,781	466,720
Maine	257,010	254,508	254,508
Maryland	340,349	337,787	341,643
Mass.	448,680	445,718	451,170
Michigan	853,557	843,318	833,321
Minnesota	361,979	357,873	357,383
Mississippi	320,499	318,030	315,443
Missouri	468,002	462,189	460,588
Montana	257,010	254,508	254,508
Nebraska	257,010	254,508	254,508
Nevada	257,010	254,508	254,508
New Hampshire	257,010	254,508	254,508

DEVELOPMENTAL DISABILITIES PROTECTION AND ADVOCACY PROGRAM

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
New Jersey	514,882	508,648	516,527
New Mexico	257,010	254,508	254,508
New York	1,401,027	1,384,019	1,384,297
North Carolina	642,167	635,921	635,552
North Dakota	257,010	254,508	254,508
Ohio	1,013,636	1,006,478	997,392
Oklahoma	309,362	306,490	307,034
Oregon	265,209	263,401	263,782
Pennsylvania	1,064,759	1,040,683	1,047,473
Puerto Rico	833,468	813,736	800,722
Rhode Island	257,010	254,508	254,508
South Carolina	368,347	368,740	366,434
South Dakota	257,010	254,508	254,508
Tennessee	501,097	495,627	495,147
Texas	1,512,690	1,501,473	1,512,208
Utah	257,010	254,508	254,508
Vermont	257,010	254,508	254,508
Virginia	502,587	502,496	505,699
Washington	388,287	384,796	385,932
West Virginia	278,368	276,991	275,697
Wisconsin	457,490	451,493	448,512
Wyoming	257,010	254,508	254,508
Indian Consortium*	137,499	136,161	136,161
Territories	687,495	647,768	613,394
Total**	26,301,079	26,047,479	26,047,479

* Funds awarded in accordance with Section 142(c) (1) (A) (i).

** Funds have been set-a-side in accordance with Section 142; therefore, total does not equal appropriation.

DEVELOPMENTAL DISABILITIES COUNCILS PROGRAM

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Alabama	1,345,843	1,350,256	1,340,972
Alaska	420,475	420,475	420,475
Arizona	998,958	1,005,402	1,016,658
Arkansas	768,612	768,612	768,612
California	6,423,100	6,494,502	6,554,934
Colorado	783,442	787,772	791,715
Connecticut	696,655	698,526	703,588
Delaware	420,475	420,475	420,475
D.C.	420,475	420,475	420,475
Florida	3,116,963	3,117,398	3,128,797
Georgia	1,718,762	1,728,262	1,728,544
Hawaii	420,475	420,475	420,475
Idaho	420,475	420,475	420,475
Illinois	2,703,092	2,705,735	2,694,055
Indiana	1,475,995	1,474,214	1,465,625
Iowa	806,646	804,511	802,559
Kansas	617,182	615,811	614,504
Kentucky	1,250,972	1,248,946	1,250,669
Louisiana	1,423,598	1,432,280	1,431,968
Maine	420,475	420,475	420,475
Maryland	976,916	979,617	979,588
Mass.	1,341,702	1,344,089	1,356,158
Michigan	2,475,657	2,480,119	2,482,101
Minnesota	1,039,371	1,034,766	1,027,766
Mississippi	942,999	949,468	948,730
Missouri	1,342,585	1,341,411	1,338,242
Montana	420,475	420,475	420,475
Nebraska	425,955	425,955	425,955
Nevada	420,475	420,475	420,475
New Hampshire	420,475	420,475	420,475

DEVELOPMENTAL DISABILITIES COUNCILS PROGRAM

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
New Jersey	1,540,860	1,523,184	1,533,682
New Mexico	479,382	479,429	480,298
New York	4,325,273	4,330,605	4,330,957
North Carolina	1,830,536	1,822,621	1,818,663
North Dakota	420,475	420,475	420,475
Ohio	2,935,874	2,950,353	2,956,009
Oklahoma	923,719	921,778	919,612
Oregon	746,575	746,859	744,861
Pennsylvania	3,219,197	3,189,640	3,208,727
Puerto Rico	2,468,561	2,428,881	2,381,894
Rhode Island	420,475	420,475	420,475
South Carolina	1,059,457	1,059,457	1,059,457
South Dakota	420,475	420,475	420,475
Tennessee	1,467,752	1,473,381	1,476,074
Texas	4,520,882	4,519,278	4,531,299
Utah	548,942	549,665	550,178
Vermont	420,475	420,475	420,475
Virginia	1,429,585	1,440,243	1,443,415
Washington	1,147,367	1,145,208	1,143,692
West Virginia	809,383	813,508	809,722
Wisconsin	1,319,250	1,321,045	1,317,695
Wyoming	420,475	420,475	420,475
Territories	1,103,750	1,048,563	993,375
Total	70,438,000	70,438,000	70,438,000

Community Services Block Grant

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Alabama	7,144,145	7,144,145	7,144,145
Alaska	1,638,575	1,638,575	1,638,575
Arizona	3,211,342	3,211,342	34,741,641
Arkansas	5,297,432	5,297,432	3,211,342
California	34,741,641	34,741,641	34,741,641
Colorado	3,387,979	3,387,979	3,387,979
Connecticut	4,699,335	4,699,335	4,699,335
Delaware	2,222,460	2,222,460	2,222,460
D.C.	6,400,754	6,400,754	2,222,460
Florida	11,322,982	11,322,982	11,322,982
Georgia	10,479,702	10,479,702	10,479,702
Hawaii	2,222,460	2,222,460	2,222,460
Idaho	2,183,758	2,183,758	2,183,758
Illinois	18,403,560	18,403,560	18,403,560
Indiana	5,672,636	5,672,636	5,672,636
Iowa	4,216,399	4,216,399	4,216,399
Kansas	3,179,945	3,179,945	3,179,945
Kentucky	6,567,924	6,567,924	6,567,924
Louisiana	9,146,057	9,146,057	9,146,057
Maine	2,222,460	2,222,460	2,222,460
Maryland	5,345,725	5,345,725	5,345,725
Mass.	9,710,720	9,710,720	9,710,720
Michigan	14,428,967	14,428,967	14,428,967
Minnesota	4,688,190	4,688,190	4,688,190
Mississippi	6,183,745	6,183,745	6,183,745
Missouri	10,780,608	10,780,608	10,780,608
Montana	2,080,349	2,080,349	2,080,349
Nebraska	2,715,584	2,715,584	2,715,584
Nevada	2,222,460	2,222,460	2,222,460
New Hampshire	2,222,460	2,222,460	2,222,460

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
New Jersey	10,672,876	10,672,876	10,672,876
New Mexico	2,186,830	2,186,830	2,186,830
New York	33,805,277	33,805,277	33,805,277
North Carolina	10,220,882	10,220,882	10,220,882
North Dakota	2,056,589	2,056,589	2,056,589
Ohio	15,186,466	15,186,466	15,186,466
Oklahoma	4,863,392	4,863,392	4,863,392
Oregon	3,113,995	3,113,995	3,113,995
Pennsylvania	16,494,107	16,494,107	16,494,107
Puerto Rico	16,412,380	16,412,380	16,412,380
Rhode Island	2,222,460	2,222,460	2,222,460
South Carolina	5,992,116	5,992,116	5,992,116
South Dakota	1,950,927	1,950,927	1,950,927
Tennessee	7,674,961	7,674,961	7,674,961
Texas	18,760,188	18,760,188	18,760,188
Utah	2,171,875	2,171,875	2,171,875
Vermont	2,222,460	2,222,460	2,222,460
Virginia	6,237,299	6,237,299	6,237,299
Washington	4,580,077	4,580,077	4,580,077
West Virginia	4,361,280	4,361,280	4,361,280
Wisconsin	4,740,198	4,740,198	4,740,198
Wyoming	2,222,460	2,222,460	2,222,460
Indians Tribes	2,473,091	2,473,091	2,473,091
Territories			
American Samoa	475,006	475,006	475,006
Guam	449,557	449,557	449,557
Mariana Islands	281,626	281,626	281,626
Palau W. Carolina	395,282	395,282	395,282
Virgin Islands	620,989	620,989	620,989
Discretionary	2,015,000	2,015,000	2,015,000
Total	389,600,000	389,600,000	389,600,000

Community Services For The Homeless

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Alabama	373,609	--	--
Alaska	61,042	--	--
Arizona	190,828	--	--
Arkansas	275,398	--	--
California	1,806,045	--	--
Colorado	176,190	--	--
Connecticut	244,379	--	--
Delaware	49,380	--	--
D.C.	332,665	--	--
Florida	588,616	--	--
Georgia	544,837	--	--
Hawaii	84,570	--	--
Idaho	52,363	--	--
Illinois	956,669	--	--
Indiana	294,921	--	--
Iowa	219,184	--	--
Kansas	165,231	--	--
Kentucky	341,517	--	--
Louisiana	475,499	--	--
Maine	106,488	--	--
Maryland	277,850	--	--
Mass.	504,813	--	--
Michigan	750,284	--	--
Minnesota	243,766	--	--
Mississippi	322,147	--	--
Missouri	560,471	--	--
Montana	73,036	--	--
Nebraska	141,167	--	--
Nevada	49,380	--	--
New Hampshire	54,834	--	--

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
New Jersey	554,800	--	--
New Mexico	129,939	--	--
New York	1,757,859	--	--
North Carolina	539,204	--	--
North Dakota	49,380	--	--
Ohio	789,446	--	--
Oklahoma	258,921	--	--
Oregon	162,280	--	--
Pennsylvania	857,481	--	--
Puerto Rico	853,208	--	--
Rhode Island	112,811	--	--
South Carolina	311,437	--	--
South Dakota	62,843	--	--
Tennessee	399,053	--	--
Texas	975,292	--	--
Utah	78,841	--	--
Vermont	56,674	--	--
Virginia	324,197	--	--
Washington	243,574	--	--
West Virginia	226,694	--	--
Wisconsin	246,467	--	--
Wyoming	49,380	--	--
Indians Tribes	296,280	--	--
Territories	98,760	--	--
Total	19,752,000	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Child Care and Development Block Grant

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation language and explanation of language changes.	I-2
Amount available for obligation	I-3
Summary of changes	I-4
Budget authority by activity	I-5
Budget authority by object	I-6
Authorizing legislation	I-7
Appropriation history table	I-9
Justification:	
A. General Statement.	I-11
B. Child Care and Development Block Grant	I-12
C. Child Development Associate Scholarships	I-15
E. Dependent Care Planning & Development Grants	I-18
F. State Tables	I-21

CHILD CARE AND DEVELOPMENT BLOCK GRANT

For carrying out sections 658A through 658R of the Omnibus Budget Reconciliation Act of 1981 (The Child Care and Development Block Grant Act of 1990), \$1,048,825,000, which shall be available for obligation under the same statutory terms and conditions applicable in the prior fiscal year.

Note. -A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families

Child Care and Development Block Grant

Amounts Available for Obligation

	1995 <u>Actual</u>	1996a/ <u>Policy</u>	1997 <u>Estimate</u>
Appropriation:			
Annual.....	\$934,642,000	\$934,642,000	\$1,048,825,000
Comparative transfer			
from:			
Children & Families			
Services Programs..	\$14,183,000	-0-	-0-
Subtotal, adjusted			
budget authority	\$948,825,000	\$934,642,000	\$1,048,825,000
Unobligated balance			
expiring.....	-0-	-0-	-0-
Total Obligations	\$948,825,000	\$934,642,000	\$1,048,825,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

SUMMARY OF CHANGES

1996 Policy.....	\$934,642,000
1997 Estimate.....	<u>\$1,048,825,000</u>
Net Change	+\$114,183,000

	<u>1996 Policy</u>	<u>Change from Base</u>
<u>Increase</u>		
A. <u>Program</u>		
1. Increase above the Child Care & Develop- ment Block Grant Base.....	\$934,642,000	+\$114,183,000
Total Increase		+\$114,183,000
Net Change		+\$114,183,000

Child Care and Development Block Grant

Budget Authority by Activity

	1995 <u>Actual</u>	1996 ^b / <u>Policy</u>	1997 <u>Estimate</u>
Child Care and Development Block Grant.....	\$948,825,000 ^a /	\$934,642,000	\$1,048,825,000
Total, budget authority	\$948,825,000	\$934,642,000	\$1,048,825,000

^a/ Includes funding for the Child Development Associate Scholarships and Dependent Care Planning and Development Grant Programs.

^b/ Based on levels of the ninth CR, including an incremental policy adjustment.

Child Care Development Block Grant

Budget Authority by Object

	FY 1996a/ <u>Policy</u>	FY 1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Consulting Services.....	\$2,323,000	\$2,622,000	+\$299,000
Grants, subsidies and contri- butions	<u>932,319,000</u>	<u>1,046,203,000</u>	<u>+\$113,884,000</u>
Total, budget authority by object	\$934,642,000	\$1,048,825,000	+\$114,183,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

Child Care and Development Block Grant

Authorizing Legislation

Activity	1996 Amount Authorized	1996 Policy	1997 Amount Authorized	1997 Estimate
Sections 658A through 658R of the Omnibus Budget Reconciliation Act of 1981, as added by Section 5082 of OBRA of 1990.....	b/	\$934,642,000 a/	b/	\$1,048,825,000 a/
Total Appropriation...	---	\$934,642,000 a/	-----	\$1,048,825,000 a/

819

Total
Appropriation
Against Definite
Authorization

a/ Funds for Child Development Associate Scholarships and Dependent Care Planning and Development Grants were proposed for consolidation under the Child Care and Development Block Grant.

b/ Authorization expired 9/30/95. Reauthorization legislation will be proposed, if necessary.

Child Care and Development Block Grant
Unfunded Authorization

1996	1997	1997
Amount	Amount	Estimate
<u>Authorized</u>	<u>Authorized</u>	
	<u>Policy</u>	

Activity

Child Development
 Associate Scholar-
 ships [Section 606
 of the Child Deve-
 lopment Associate
 Scholarship Assist-
 ance Act of 1985,
 as amended]

a/

Dependent Care
 Planning and Deve-
 lopment [Sec. 670A
 of the State Depen-
 dent Care Grants
 Act, as amended]

a/

a/ Activities previously funded under this authority are now carried out under the Child
 Care and Development Block Grant.

APPROPRIATION HISTORY TABLE
Child Care and Development Block Grant

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1992 <u>1</u> /	744,925,000	850,000,000	838,000,000	\$825,000,000
1993 <u>2</u> /	850,000,000	841,500,000	975,000,000	892,711,000
1994 <u>3</u> /	958,964,000	892,711,000	892,711,000	892,711,000
1995 <u>4</u> /	1,090,662,000	934,642,000	934,642,000	934,642,000
1996	1,048,825,000	934,642,000	934,642,000 <u>5</u> /	934,642,000 <u>6</u> /
1997	1,048,825,000			

- 1/ Budget estimate to Congress included \$731,925,000 for the Child Care and Development Block Grant and \$13,000,000 for Child Care Licensing Improvement Grants. House Allowance included \$825,000,000 for the Child Care and Development Block Grant and \$25,000,000 for Child Care Licensing Improvement Grants. Senate allowance included \$825,000,000 for the Child Care and Development Block Grant and \$13,000,000 for Child Care Licensing Improvement Grants. Appropriation did not include funds for Child Care Licensing Improvement Grants.
- 2/ The initial appropriation of \$900,000,000 was subsequently reduced as a result of mandated cuts.
- 3/ Budget estimate to Congress included \$932,711,000 for the Child Care and Development Block Grant, \$1,372,000 for Child Development Associate Scholarships, \$11,942,000 for Temporary Child Care and Crisis Nurseries and \$12,939,000 for Dependent Care Planning and Development Grants.
- 4/ Budget estimate to Congress included \$1,090,662,000 for the Child Care and Development Block Grant, \$0 for Child Development Associate Scholarships and \$0 for Dependent Care Planning and Development Grants. House and Senate Allowance included \$934,656,000 for the Child Care and Development Block Grant which was reduced to \$934,642,000 pursuant P.L. 103-333. In addition, Congress separately provided \$1,360,000 for Child Development Associate

Scholarships and \$12,823,000 for Dependent Care Planning and Development Grants. The comparable appropriation for the consolidation proposed in the President's budget is \$948,825,000.

5/ Senate Committee Mark.

6/ Based on levels of the ninth CR, including an incremental policy adjustment.

Justification

Child Care and Development Block Grant

	<u>1996</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
Child Care and Development Block Grant...	<u>\$934,642,000</u>	<u>\$1,048,825,000</u>	<u>+\$114,183,000</u>
Total, budget authority	\$934,642,000	\$1,048,825,000	+\$114,183,000

General Statement

The Child Care and Development Block Grant was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990).

Seventy-five percent of the Child Care and Development Block grant funds are available for child care services and activities to improve the availability, accessibility and affordability of child care. By law, a preponderance of the 75 percent must be made available for direct services.

The remaining 25 percent of funds are reserved for quality improvement activities for child care and for early childhood development and before- and after-school services. Of the twenty-five percent of funds reserved: (1) 20% must be used for quality activities including child care resource and referral activities; grants or loans to help providers meet State or local standards; improving the monitoring of compliance with, and enforcement of, State and local standards and licensing and regulatory requirements; providing training and technical assistance; and, improving salaries and other compensation paid to child care providers; (2) 75% must be used to establish or expand and conduct early childhood development and/or before- and after-school child care programs; and, (3) the remaining 5 percent may be used for either category of activity. Child Care and Development Block Grant funds are available to States, territories, and Indian tribes.

The President's appropriation request of \$1,048,825,000 for this account represents current law requirements. No proposed law amounts are included.

Child Care and Development Block Grant

Authorizing Legislation - Sections 658A through 658R of the Omnibus Budget Reconciliation Act of 1981, as amended. Expired September 30, 1995.

<u>1995 Enacted</u>	<u>1996b/ Policy</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$948,825,000a/	\$934,642,000	\$1,048,825,000	+\$114,183,000

- a/ Includes funds from Child Development Associate Scholarships and Dependent Care Planning and Development Grant Programs.
- b/ Based on levels of the ninth CR, including an incremental policy adjustment.

FY 1997 Authorization Authorizing legislation expired September 30, 1995. Reauthorizing legislation will be proposed, if necessary.

Purpose and Method of Operations

The Child Care and Development Block Grant provides grants to States, federally recognized Tribes and territories for the purposes of providing low-income families with financial assistance for child care, improving the quality and availability of child care, and for establishing or expanding and conducting early childhood development programs and before- and after-school programs.

Federal funds provide grants, contracts, and certificates for child care services to low-income families with a parent who is working or attending a training or educational program. Certificates allow parents to choose from a broad range of providers, from for-profit centers to a neighbor's or relative's home. This program is designed to enable low-income families to remain self-sufficient.

Funds for this program are allotted to each State based upon a formula that includes the relative per capita income of each State, each State's share of the total national number of children under the age of 5, and the percentage of children receiving free or reduced price school lunches in each State. Up to 3 percent of the total funding is reserved for Indian Tribes

and up to one-half of one percent is available to the territories.

Comparable funding for the consolidated Child Care and Development Block Grant program, including funding for the three predecessor programs, for the past five years, has been:

1992.....	\$839,572,000
1993.....	\$907,022,000
1994.....	\$906,952,000
1995.....	\$948,825,000
1996.....	\$934,642,000

Rationale for the Budget Request

The FY 1997 budget request includes a \$114 million increase in funding for the Child Care and Development Block Grant. The additional \$114 million request will allow an increase in the number of low-income families who can begin or continue to work or participate in training and education. All across the country, there are long waiting lists of low income working parents in need of child care assistance. Critical components of child care services, such as training and technical assistance, quality improvements, and health and safety protection can also benefit from this increase in funding.

Moreover, enhanced Child Care and Development Block Grant funding will enable States, federally recognized Tribes and territories to continue improving the quality of child care programs. Grantees have used funds to strengthen the quality of the whole system by such efforts as supporting child care monitoring, establishing child care provider mentoring and training programs. Funds will be available for States to continue support for assessment and credentialing of Child Development Associates, for developing before and after-school child care programs and for supporting child care resource and referral.

Name of Program: Child Care & Development Block Grant

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	\$932,319,000	\$932,319,000	\$1,046,203,000
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	2,323,000	2,323,000	2,622,000
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	\$934,642,000	\$934,642,000	\$1,048,825,000
Number of Applicants	289	302	350
Number of Grants	289	299	310
New Starts:			
#	10	10	11
\$	1,216,000	1,215,000	1,353,000
Continuations:			
#	279	289	299
\$	931,103,000	931,104,000	1,044,850,000
Contracts:			
#	1	1	1
\$	2,323,000	2,323,000	2,622,000

Child Development Associate Scholarship Program

Authorizing Legislation - Section 606 of the Child Development Associate Scholarship Assistance Act, as amended. Expired September 30, 1995.

<u>FY 1995</u> <u>Enacted</u>	<u>FY 1996a/</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$1,360,000	--	--	--

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

FY 1997 Authorization..... None.

Purpose and Method of Operations

The current Child Development Associate Scholarship program, proposed in FY 1996 for consolidation with the Child Care and Development Block Grant, awards grants to States to enable them to provide for scholarships to financially eligible individuals who are candidates for the Child Development Associate (CDA) Credential. It was initiated in 1972 to improve the quality of child care by improving, evaluating, and recognizing the competence of center-based staff working with preschoolers or infants and toddlers, family day care providers, and home visitors. A bilingual specialization is available. Forty-nine States and the District of Columbia list the CDA credential in their child care licensing regulations as a qualification for teaching staff and/or directors.

According to the authorizing legislation, scholarship assistance shall be awarded to income-eligible candidates to cover the cost of application, assessment, and credentialing. The term "income eligible" is defined in the statute as a candidate for the CDA credential whose income does not exceed 130 percent of the Lower Living Standards Income Level by more than 50 percent. A State may use up to 35 percent of its award to provide scholarship assistance to cover the cost of CDA training necessary for credentialing. Not more than ten percent of the funds received by the State may be used for the costs of administering the program.

The amount of each State's allotment is determined based on the State's total population compared to total current population estimates.

Funding for the Child Development Associate Scholarship Program during the last five years has been as follows:

1992.....	\$1,397,000
1993.....	\$1,372,000
1994.....	\$1,372,000
1995.....	\$1,360,000
1996.....	-0-

Rationale for the Budget Request

There is no budget request for this program in FY 1997. States will continue to have the flexibility under the Block Grant to provide credentialing assistance for child care workers.

Name of Program: Child Development Associate Scholarships

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	--	--	--
Discretionary	\$1,360,000	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	1,360,000	--	--
Number of Applicants	--	--	--
Number of Grants	54	--	--
New Starts:			
#	54	--	--
\$	1,360,000	--	--
Continuations:			
#	--	--	--
\$	--	--	--
Contracts:			
#	--	--	--
\$	--	--	--

Dependent Care Planning and Development

Authorizing Legislation - Section 670A of the State Dependent Care Grants Act, as amended. Expired September 30, 1995.

<u>FY 1995 Enacted</u>	<u>FY 1996^a/ Policy</u>	<u>FY 1997 Request</u>	<u>Increase or Decrease</u>
\$12,823,000	--	--	--

^a/ Based on levels of the ninth CR, including an incremental policy adjustment.

FY 1997 Authorization..... None.

Purpose and Method of Operations

The Dependent Care Planning and Development program provides grants to States for activities in two specific areas: 1) 40 percent of allotted funds must be used for activities related to dependent care resource and referral systems, and 2) 60 percent of allotted funds must be used for activities related to school-age child care services. HHS may waive the percentage requirements for these two areas at the request of a State.

Funds are allotted to States by formula. Each State receives an amount which bears the same ratio to the total amount appropriated as the population of the State bears to the population of all States. Funds for Dependent Care Programs in the Territories and Insular Areas may be consolidated with the Social Services Block Grant, at the option of the Territory or Insular Area.

States have used Dependent Care Grant funds to: improve the accessibility of resource and referral services for children, the elderly, and the disabled; develop and disseminate resource and referral materials for the dependent care populations; enhance the capability of resource and referral systems to provide comprehensive and effective services; provide training for before and after school services and to operate such facilities; provide direct technical assistance to communities and groups; and, develop comprehensive training materials to assist new programs.

Funding for Dependent Care Planning and Development program during the last five years has been as follows:

1992.....	\$13,175,000
1993.....	\$12,939,000
1994.....	\$12,939,000
1995.....	\$12,823,000
1996.....	-0-

Rationale for the Budget Request

There is no budget request for this program in FY 1997. States already have the flexibility under the Block Grant to support information and referral systems, as well as school-age child care services.

Name of Program: Dependent Care Planning & Development Grant

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	\$12,823,000	--	--
Discretionary	--	--	--
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	--
Evaluation	--	--	--
Program Support	--	--	--
Other	--	--	--
TOTAL PROGRAM	\$12,823,000	--	--
Number of Applicants	54	--	--
Number of Grants	54	--	--
New Starts:			
#	--	--	--
\$	--	--	--
Continuations:			
#	54	--	--
\$	12,823,000	--	--
Contracts:			
#	--	--	--
\$	--	--	--

STATE TABLES

CHILD CARE AND DEVELOPMENT BLOCK GRANT

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
Alabama	\$19,754,442	\$19,754,442	\$22,168,019
Alaska	1,869,544	1,869,544	2,097,943
Arizona	16,870,915	16,870,915	18,931,995
Arkansas	11,036,246	11,036,246	12,384,519
California	106,608,587	106,608,587	119,632,710
Colorado	10,268,488	10,268,488	11,522,965
Connecticut	6,700,879	6,700,879	7,519,509
Delaware	1,833,102	1,833,102	2,057,047
Dist. of Columbia	1,779,586	1,779,586	1,996,993
Florida	45,853,254	45,853,254	51,455,039
Georgia	29,310,867	29,310,867	32,891,707
Guam	2,094,331	2,094,331	2,350,190
Hawaii	3,237,634	3,237,634	3,633,167
Idaho	4,685,342	4,685,342	5,257,739
Illinois	34,620,328	34,620,328	38,849,813
Indiana	17,356,931	17,356,931	19,477,387
Iowa	8,696,272	8,696,272	9,758,676
Kansas	8,271,198	8,271,198	9,281,670
Kentucky	16,926,183	16,926,183	18,994,016
Louisiana	25,578,823	25,578,823	28,703,728
Maine	3,737,104	3,737,104	4,193,657
Maryland	11,969,630	11,969,630	13,431,931
Massachusetts	12,914,402	12,914,402	14,492,125
Michigan	27,747,252	27,747,252	31,137,069
Minnesota	12,908,723	12,908,723	14,485,751
Mississippi	16,835,343	16,835,343	18,892,077
Missouri	16,973,700	16,973,700	19,047,337
Montana	3,073,862	3,073,862	3,449,388
Nebraska	5,255,751	5,255,751	5,897,834
Nevada	3,653,735	3,653,735	4,100,103

CHILD CARE AND DEVELOPMENT BLOCK GRANT (continued)

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
New Hampshire	2,308,912	2,308,912	2,590,987
New Jersey	17,080,557	17,080,557	19,167,249
New Mexico	8,667,898	8,667,898	9,726,835
New York	53,097,965	53,097,965	59,584,820
North Carolina	26,214,014	26,214,014	29,416,519
North Dakota	2,345,886	2,345,886	2,632,477
Ohio	33,959,626	33,959,626	38,108,395
Oklahoma	14,156,324	14,156,324	15,885,770
Oregon	9,371,929	9,371,929	10,516,876
Pennsylvania	31,045,612	31,045,612	34,838,382
Puerto Rico	24,921,065	24,921,065	27,965,613
Rhode Island	2,641,778	2,641,778	2,964,518
South Carolina	17,233,196	17,233,196	19,338,535
South Dakota	3,217,450	3,217,450	3,610,518
Tennessee	19,681,998	19,681,998	22,086,501
Texas	81,384,655	81,384,655	91,327,229
Utah	8,771,960	8,771,960	9,843,609
Vermont	1,592,285	1,592,285	1,786,810
Virgin Islands	1,469,357	1,469,357	1,648,865
Virginia	17,343,096	17,343,096	19,461,862
Washington	15,016,025	15,016,025	16,850,497
West Virginia	7,187,766	7,187,766	8,065,879
Wisconsin	14,437,186	14,437,186	16,200,943
Wyoming	1,669,186	1,669,186	1,873,106
North Mariana Islands	791,887	791,887	888,631
Palau	305,950	305,950	343,327
Indian Tribe Set Aside	27,969,155	27,969,155	31,386,081
Discretionary	2,336,605	2,336,605	2,622,062
Total, Budget Authority	\$934,641,777	\$934,641,777	\$1,048,825,000

CHILD DEVELOPMENT ASSOCIATE SCHOLARSHIP ASSISTANCE

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
Alabama	21,636	--	--
Alaska	3,071	--	--
Arizona	20,046	--	--
Arkansas	12,549	--	--
California	161,471	--	--
Colorado	18,152	--	--
Connecticut	17,164	--	--
Delaware	3,604	--	--
District of Columbia	3,081	--	--
Florida	70,558	--	--
Georgia	35,315	--	--
Guam	2,397	--	--
Hawaii	6,068	--	--
Idaho	5,582	--	--
Illinois	60,844	--	--
Indiana	29,619	--	--
Iowa	14,710	--	--
Kansas	13,199	--	--
Kentucky	19,643	--	--
Louisiana	22,426	--	--
Maine	6,461	--	--
Maryland	25,674	--	--
Massachusetts	31,377	--	--
Michigan	49,366	--	--
Minnesota	23,436	--	--
Mississippi	13,674	--	--
Missouri	27,165	--	--
Montana	4,311	--	--
Nebraska	8,401	--	--
Nevada	6,942	--	--
New Hampshire	5,812	--	--
New Jersey	40,745	--	--
New Mexico	8,271	--	--
New York	94,784	--	--

CHILD DEVELOPMENT ASSOCIATE SCHOLARSHIP ASSISTANCE (continued)

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
North Carolina	35,797	--	--
North Dakota	3,327	--	--
Northern Mariana ISL	2,397	--	--
Ohio	57,627	--	--
Oklahoma	16,803	--	--
Oregon	15,574	--	--
Pennsylvania	62,822	--	--
Puerto Rico	18,424	--	--
Rhode Island	5,258	--	--
South Carolina	18,848	--	--
South Dakota	3,719	--	--
Tennessee	26,281	--	--
Texas	92,362	--	--
Utah	9,484	--	--
Vermont	2,982	--	--
Virgin Islands	2,397	--	--
Virginia	33,360	--	--
Washington	26,868	--	--
West Virginia	9,479	--	--
Wisconsin	26,193	--	--
Wyoming	2,444	--	--
Total, Budget Authority	1,360,000	--	--

DEPENDENT CARE PLANNING AND DEVELOPMENT PROGRAM

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
Alabama	202,516	--	--
Alaska	50,000	--	--
Arizona	190,375	--	--
Arkansas	117,243	--	--
California	1,509,602	--	--
Colorado	172,479	--	--
Connecticut	158,501	--	--
Delaware	50,000	--	--
District of Columbia	50,000	--	--
Florida	661,622	--	--
Georgia	334,559	--	--
Hawaii	56,735	--	--
Idaho	53,204	--	--
Illinois	565,757	--	--
Indiana	276,325	--	--
Iowa	136,107	--	--
Kansas	122,419	--	--
Kentucky	183,265	--	--
Louisiana	207,739	--	--
Maine	59,928	--	--
Maryland	240,146	--	--
Massachusetts	290,787	--	--
Michigan	458,429	--	--
Minnesota	218,477	--	--
Mississippi	127,836	--	--
Missouri	253,157	--	--
Montana	50,000	--	--
Nebraska	77,727	--	--
Nevada	67,183	--	--
New Hampshire	54,462	--	--

DEPENDENT CARE PLANNING AND DEVELOPMENT PROGRAM (continued)

STATE	1995 ENACTED	1996 POLICY	1997 REQUEST
New Jersey	381,089	--	--
New Mexico	78,162	--	--
New York	880,147	--	--
North Carolina	335,914	--	--
North Dakota	50,000	--	--
Ohio	536,446	--	--
Oklahoma	156,276	--	--
Oregon	146,651	--	--
Pennsylvania	582,347	--	--
Puerto Rico	173,164	--	--
Rhode Island	50,000	--	--
South Carolina	176,204	--	--
South Dakota	50,000	--	--
Tennessee	246,627	--	--
Texas	872,118	--	--
Utah	89,964	--	--
Vermont	50,000	--	--
Virginia	313,955	--	--
Washington	254,172	--	--
West Virginia	88,029	--	--
Wisconsin	243,676	--	--
Wyoming	50,000	--	--
American Samoa	2,290	--	--
Guam	6,519	--	--
Marshall Islands	1,511	--	--
Micronesia	3,313	--	--
Northern Marianas	2,122	--	--
Palau	740	--	--
Virgin Islands	4,984	--	--
Total, Budget Authority	\$12,823,000	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Refugee and Entrant Assistance.

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation language and explanation of language changes .	J-2
Amounts available for obligation	J-3
Summary of changes	J-4
Budget authority by activity	J-5
Budget authority by object	J-6
Significant Items in House and Senate Appropriations	
Committee Reports	J-7
Authorization legislation.	J-8
Appropriation history table	J-9
Justification:	
A. General Statement	J-11
B. Transitional and Medical Services	J-13
C. Social Services.	J-17
D. Preventive Health	J-20
E. Targeted Assistance	J-22
F. State Tables	J-25

REFUGEE AND ENTRANT ASSISTANCE

For making payments for refugee and entrant assistance activities authorized by title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-422), \$381,536,000.

Note.-A regular 1996 appropriation for the account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

[Refugee Resettlement Assistance]

[For necessary expenses for the targeted assistance program authorized by title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980 and administered by the Office of Refugee Resettlement of the Department of Health and Human Services, in addition to amounts otherwise available for such purposes, \$5,000,000.] (*Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1996.*)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Refugee and Entrant Assistance

Amounts Available for Obligation

	1995 <u>Actual</u> ¹	1996 <u>Policy</u> ²	1997 <u>Estimate</u>
Appropriation:			
Annual....	\$405,779,000	\$404,800,000	\$381,536,000
Procurement reduction pursuant to P.L. 103-333.....	-6,999	---	---
Subtotal, adjusted appropriation....	405,772,001	404,800,000	381,536,000
Unobligated balance, start of year.....	2,332,000	2,332,000	2,332,000
Unobligated balance, end of year	-2,332,000	-2,332,000	-2,332,000
Unobligated balance, lapsing...	-9,536,488	---	---
Total, Obligations	\$396,235,513	\$404,800,000	\$381,536,000

¹ Includes \$6,000,000 for Targeted Assistance, appropriated in P.L. 103-306.

² Based on levels of the ninth CR, including an incremental policy adjustment and \$5,000,000 for Targeted Assistance appropriated in P.L. 104-107, The Foreign Operations Appropriations Act.

SUMMARY OF CHANGES

1996 Policy.....	\$404,800,000 ¹
1997 Request.....	<u>381,536,000</u>
Net change.....	-\$23,264,000

	1996 Current Estimate Base	Change from Base
Increases:		
A. Preventive		
Health - to provide		
traditional levels		
of support	2,700,000	+\$ 2,135,000
Total increases.....		+\$ 2,135,000
Decreases:		
<u>Program:</u>		
A. Transitional and		
Medical Services -		
to provide 8 months of		
services	266,901,000	-20,399,000
B. Targeted Assistance -		
to return to traditional		
levels of support	\$54,397,000	-\$5,000,000
Total decreases.....		-\$25,399,000
Net Change.....		-\$23,264,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment and \$5,000,000 for Targeted Assistance appropriated in P.L.104-107, the Foreign Operations Appropriations Act.

Budget Authority by Activity

	1995 <u>Actual</u> ^{1 2}	1996 <u>Policy</u> ³	1997 <u>Estimate</u>
1. Transitional and Medical Services.	\$260,273,001	\$266,901,000	\$246,502,000
2. Social Services.	84,802,000	80,802,000	80,802,000
3. Preventive Health...	5,300,000	2,700,000	4,835,000
4. Targeted Assistance	55,397,000	54,397,000	49,397,000
Total, Budget Authority....	\$405,772,001	\$404,800,000	\$381,536,000

¹ Includes \$6,000,000 for Targeted Assistance, appropriated in P.L. 103-206.

² Reflects an approved reprogramming of \$4,000,000 from Transitional and Medical Services to Social Services.

³ Based on levels on the ninth CR, including an incremental policy adjustment and \$5,000,000 for Targeted Assistance, appropriated in P.L. 104-107, the Foreign Operations Appropriations Act.

Budget Authority by Object

	<u>1996 Actual</u>	<u>1996 Policy¹</u>	<u>Increase or Decrease</u>
Other Services (Interagency agreements, supportive services, etc.)	2,900,000	2,900,000	---
Purchase of goods and services	636,000	635,000	---
Grants, subsidies, and contribu- tions	401,264,000	378,000,000	-\$23,264,000
Total, budget authority by object....	\$404,800,000	\$381,536,000	-\$23,264,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment and \$5,000,000 for Targeted Assistance appropriated in P.L. 104-107, the Foreign Operations Appropriations Act.

SIGNIFICANT ITEMS IN HOUSE AND SENATE APPROPRIATIONS
COMMITTEE REPORTS1996 House Appropriations Committee Report LanguageItem

Social Services and preventive health--...The Committee is also concerned that funding for States and local governments for domestic health assessment activities has not been administered in the most cost effective manner and directs that program activities be administered directly by the Office of Refugee Resettlement.

Action Taken or to be Taken

Pursuant to this guidance, the Office Refugee Resettlement intends to administer this program.

Authorizing Legislation

	1996 Amount <u>Authorized</u>	1996 <u>Policy</u> ¹	1997 Amount <u>Authorized</u>	1997 <u>Estimate</u>
<u>Refugee and</u>				
<u>Entrant</u>				
<u>Assistance</u>				
<u>Activities:</u>				
Section 414 (a) of the Immigration and Nationality Act, as amended and Section 501 of the Refugee Education Asst. Act of 1980				
1. Transitional and Medical Services..	such sums	266,901,000	such sums	246,502,000
2. Social Services..	such sums	80,802,000	such sums	80,802,000
3. Preventive Health....	such sums	2,700,000	such sums	4,835,000
4. Targeted Assistance	such sums	54,397,000	such sums	49,397,000
Total, appropriation...		\$404,800,000		\$381,536,000
Total appropriation against definite authorizations...	---	---	---	---

¹ Based on levels of the ninth CR, including an incremental policy adjustment and \$5,000,000 for Targeted Assistance appropriated in P.L. 104-107, the Foreign Operations Appropriations Act.

APPROPRIATION HISTORY TABLE

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1986 ^{a/}	310,737,000	Deferred	Deferred	421,486,000
Sequester	---	---	---	-18,123,000
Rescission	---	---	---	87,551,000
1987	367,915,000	Deferred	Deferred	339,597,000 ^{b/}
1988	346,933,000 ^{b/}	320,855,000	389,597,000	346,933,000
1989	278,883,000	Deferred	400,000,000	382,356,000 ^{c/}
1990	368,822,000	Deferred	417,356,000	389,758,000
1991	368,822,000	Deferred	398,000,000	420,770,000 ^{d/}
Sequester	---	---	---	-10,146,338
1992	410,630,000	294,014,000	410,630,000	410,630,000
1993	227,000,000	321,750,000	405,114,000	381,481,000
Suppl.	27,000,000	---	---	---
1994	420,052,000	400,000,000	400,000,000	399,778,814 ^{e/}
1995	413,786,000	405,779,000	405,779,000	405,772,001
1996				
Policy	414,199,000	416,781,000	397,172,000 ^{d/}	404,800,000 ^{f/}
1997	381,526,000			

^{a/} All amounts shown for FY 1986 and later years exclude Federal Administration which was consolidated into the Family Support Administration's Program Administration budget activity (the Administration for Children and Families' Program Direction account beginning in FY 1992).

^{b/} Under a provision of the Refugee Assistance Extension Act of 1986, P.L. 99-605, the Education Assistance function was transferred from the Department of Health and Human Services to the Department of Education. The budget figure shown contains no amount for Education Assistance.

^{c/} The appropriation of \$387,000,000 was reduced by \$4,644,000 pursuant to P.L. 100-436.

4/ The appropriation of \$420,770,000 was reduced by \$10,140,000 pursuant to P.L. 101-517.

5/ The appropriation of \$400,000,000 was reduced by a rescission of \$221,186 for administrative cost reductions.

6/ Based on levels of the ninth CR, including an incremental policy adjustment and \$5,000,000 for Targeted Assistance appropriated in P.L. 104-107, the Foreign Operations Appropriations Act.

7/ Senate Committee Mark.

Justification

Office of Refugee Resettlement

	1996 <u>Policy¹</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Transi- tional and Medical Services...	\$ 266,901,000	\$246,502,000	-\$20,399,000
Social Services...	80,802,000	80,802,000	---
Preventive Health.....	2,700,000	4,835,000	+2,135,000
Targeted Assistance.	54,397,000	49,397,000	-5,000,000
Total, Budget Authority	\$404,800,000	\$381,536,000	-\$23,264,000

General Statement

The Refugee and Entrant Assistance program is designed to help refugees and Cuban and Haitian entrants who are admitted into the United States to become employed and self-sufficient as quickly as possible. The President's appropriation request of \$381,536,000 for this account represents the amount needed to maintain current assistance levels.

Transitional and Medical Services funds support:

- o Cash and medical assistance to refugee households that not categorically eligible for AFDC, Medicaid and SSI during their first months in the United States. This program is operated by State refugee program offices.

¹ Based on levels of the ninth CR, including an incremental policy adjustment an \$5,000,000 for Targeted Assistance, appropriated in P.L. 104-107, the Foreign Operations Appropriations Act.

- o State reimbursements for costs incurred to administer refugee program activities and the provision of assistance and services to unaccompanied minors.
- o Voluntary refugee resettlement agencies, which provide an equal match for Federal dollars.

The Social Services activity assists refugees in becoming socially adjusted, employed and self-sufficient as rapidly as possible. Services include English language training, employment-related services, and a variety of special projects and activities.

The Refugee and Entrant Assistance program also supports programs which: provide targeted assistance grants to States for counties which are impacted by high concentrations of refugees; and provide medical screening of refugees to preserve the public health and assure that health problems are not a barrier to achieving self-sufficiency.

In FY 1995 the Committee added bill language to allow funds appropriated but not spent in FY 1993 to be carried forward into FY 1994 and 1995. Spending for this provision scored at \$14 million, but the Committee reduced the FY 1995 appropriation by an equal amount. In FY 1996, the Administration did not request bill language similar to that requested in FY 1995, but both the House and the Senate Committee report language added language to allow an estimated \$10 million in carryover balances from FY 1994 to support FY 1996 costs. For FY 1997, language to use carryover balances is not requested.

The FY 1997 request is based on the assumption that 90,000 persons eligible for the refugee program will be admitted to the United States during FY 1997, including 75,000 refugees and 15,000 parolees from Cuba.

	<u>Ceiling</u>	<u>Arrivals</u>
1985	70,000	67,167
1986	67,000	60,554
1987	70,000	58,885
1988	87,500	76,733
1989	116,500	106,538
1990	125,000	122,263
1991	131,000	113,734
1992	132,000	131,611
1993	120,000	119,063
1994	120,000	119,500
1995	110,000	
1996	110,000	
1997	90,000	(Including 15,000 Cubans/Haitians)

Transitional and Medical Services

Authorizing Legislation - Section 414 of Title IV of the Immigration and Nationality Act and Section 501 of Title V of the Refugee Education Assistance Act of 1980. Authorizing legislation expires September 30, 1997.

<u>1995 Actual</u>	<u>1996 Policy¹</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$260,273,001 ²	\$266,901,000	\$246,502,000	-\$20,399,000

1997 Authorization: Such sums

Purpose and Method of Operations

This program provides funds for cash and medical assistance, unaccompanied minors and voluntary agencies. This State-administered cash and medical assistance program provides assistance to refugees who are not categorically eligible for AFDC, Medicaid, or SSI during their first months in the United States. Assistance may be provided through existing State-administered programs, as well as through special refugee resettlement program during an initial period of transition towards self-support. State administrative costs are supported as well.

Also provided is assistance for unaccompanied minors. Historically, assistance to unaccompanied minors has been the top priority for the cash and medical assistance program. This activity reimburses States for providing foster care to an unaccompanied minor until the child reaches the age of eighteen. If a State has established a later age for emancipation from foster care, reimbursements will be provided until that date.

The Voluntary Agency Program was first funded by Congress in FY 1979. Under the program, participating national voluntary refugee resettlement agencies provide a match (in cash and in-kind services) for the Federal contribution. The participating agencies provide services such as case management,

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

² The appropriation of \$264,273,000 was adjusted through an approved reprogramming of \$4 million to Social Services.

job development, job placement and follow-up, and financial assistance to eligible refugees. Participating refugees may not access public cash assistance.

On a comparable basis, funding for this activity over the past five years has been:

FY 1992.....	273,252,000
FY 1993.....	245,811,000
FY 1994.....	258,279,951 ¹
FY 1995.....	260,273,000 ²
FY 1996 Policy.....	266,901,000

Rationale for the Budget Request

For FY 1997, \$246,502,000 is requested, a decrease of \$20,399,000 from the FY 1996 Policy level. The request will continue to support eight months of cash and medical assistance to eligible refugees, including unaccompanied minors, under both State-administered programs and voluntary agency programs. The request would continue to assist needy refugees who meet States' financial eligibility requirements for AFDC but who do not meet the categorical eligibility requirements for AFDC, Medicaid, or SSI. Approximately \$39,000,000 will be used to support grants under the Voluntary Agency Grant program. Funding in this account will continue to be focused on programs which provide specific interventions designed to foster refugees' self-sufficiency.

¹ Reflects reprogramming of \$6,000,000 from Transitional and Medical Services to Targeted Assistance.

² Reflects an approved reprogramming of \$4 million from Transitional and Medical Services to Social Services.

Refugee Resettlement: Transitional and Medical Services

Program Data:

	FY 1995 <u>Actual</u> ¹	FY 1996 <u>Policy</u> ²	FY 1997 <u>Request</u>
Service Grants			
Formula	229,001,924	235,632,000	203,257,000
Discretionary	31,271,077	30,834,000	42,780,000
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	325,000	325,000
Program Support	---	---	---
Other ³	---	110,000	140,000

¹ Initial appropriation of \$264,280,000 reduced by an administrative cost reduction of \$6,999 and reprogramming of \$4 million to Social Services.

² Based on level of the ninth CR, including an incremental policy adjustment.

³ Monitoring and data collection.

Total Program	\$260,273,001	\$266,901,000	\$246,502,000
Number of Applicants	64	62	62
Number of Grants	234	209	210
New Starts:			
#	1	1	1
\$	\$2,391,101	\$2,351,034	\$2,200,000
Continuations:			
#	233	208	209
\$	\$257,881,900	\$264,114,966	\$243,837,000
Contracts:			
#	---	2	2
\$	\$0	\$435,000	\$465,000

Social Services

Authorizing Legislation - Section 414 of Title IV of the Immigration and Nationality Act and Section 501 of Title V of the Refugee Education Assistance Act of 1980. Authorizing legislation expires September 30, 1997.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy</u> ¹	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$84,802,000 ²	\$80,802,000	\$80,802,000	---

1997 Authorization: Such sums.

Purpose and Method of Operations

This activity provides Federal funds for State-administered programs emphasizing employment-related activities. Social Services assist refugees in obtaining employment and social adjustment, and achieving economic self-sufficiency as quickly as possible. Highest priorities are given to English language training, case management, and job placement. State and local governments, voluntary agencies, and refugee-based mutual assistance associations are consulted annually concerning the effective use of these funds.

Of the funds appropriated, approximately 85 percent is allocated by formula among the States and the District of Columbia. The remainder supports special discretionary projects such as services for Amerasians from Vietnam and former re-education camp detainees from Vietnam.

Funding for this activity over the past five years has been:

FY 1992.....	82,952,000
FY 1993.....	80,802,000
FY 1994.....	80,802,000
FY 1995.....	84,802,000
FY 1996.....	80,802,000

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

² Reflects an approved reprogramming of \$4 million from Transitional and Medical Services to Social Services.

Rationale for the Budget Request

In FY 1997 the request for social services is \$80,802,000, the same as the FY 1996 Policy level. With emphasis on self-sufficiency for refugees as soon as possible after their arrival in the United States, this request, together with a similar emphasis under the voluntary agency matching grant program, will provide employment-related and social adjustment services to new and recently arrived refugees.

Refugee Resettlement: Social Services

Program Data:

	FY 1995 <u>Actual</u> ¹	FY 1996 <u>Policy</u> ²	FY 1997 <u>Request</u>
Service Grants			
Formula	68,661,222	68,681,700	68,681,700
Discretionary	15,894,186	11,920,300	11,920,300
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support ³	246,592	200,000	200,000
Other	---	---	---
 Total Program	 \$84,802,000	 \$80,802,000	 \$80,802,000
Number of Applicants	166	146	146
Number of Grants	285	280	280
New Starts:			
#	23	20	
\$	\$6,888,155	\$3,500,000	\$
Continuations:			
#	262	260	
\$	\$77,667,253	\$77,102,000	\$
Contracts:			
#	1	1	
\$	\$246,592	\$200,000	\$

¹ Reflects an approved reprogramming of \$4 million from Transitional and Medical Services to Social Services.

² Based on levels of the ninth CR, including an incremental policy adjustment.

³ Conference contract.

Preventive Health

Authorizing Legislation - Section 414 of Title IV of the Immigration and Nationality Act and Section 501 of Title V of the Refugee Education Assistance Act of 1980. Authorizing legislation expires September 30, 1997.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy</u> ¹	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$5,300,000	\$2,700,000	\$4,835,000	+\$2,135,000

1997 Authorization: Such sums

Purpose and Method of Operations

The Office of Refugee Resettlement recognizes that a refugee's medical condition may affect the public health as well as prevent a refugee from achieving economic self-sufficiency. These funds support grants to States to provide health screening/assessment services to refugees.

This activity provides Federal funding of grants to States to provide health screening/assessment services to refugees.

Funding for this line item over the past five years has been:

FY 1992.....	5,631,000
FY 1993.....	5,471,000
FY 1994.....	5,229,863
FY 1995.....	5,300,000
FY 1996 Policy.....	2,700,000

Rationale for the Budget Request

For FY 1997, \$4,835,000 is requested, an increase of \$2,135,000 over the 1996 Policy level. This increase will ensure adequate health assessment activities for refugees.

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

Refugee Resettlement: Preventive Health

Program Data:	<u>FY 1995 Actual</u>	<u>FY 1996 Policy ¹</u>	<u>FY 1997 Request</u>
Service Grants			
Formula	---	---	---
Discretionary	---	2,700,000	4,835,000
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other ²	5,300,000	---	---
Total Program	\$5,300,000	\$2,700,000	\$4,835,000
Number of Applicants	NA	NA	NA
Number of Grants			
New Starts:			
#	NA	NA	45
\$	\$---	\$---	\$4,835,000
Continuations:			
#	NA	45	NA
\$	\$---	\$2,700,000	\$---
Contracts:			
#	1	0	0
\$	\$5,300,000	\$---	\$---

¹ Based on levels of the ninth CR, including an incremental policy adjustment.

² Interagency agreement with the Public Health Service.

Targeted Assistance

Authorizing Legislation - Section 414 of Title IV of the Immigration and Nationality Act and Section 501 of Title V of the Refugee Education Assistance Act of 1980. Authorizing legislation expires September 30, 1997.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy¹</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$55,397,000	\$54,397,000	\$49,397,000	-\$5,000,000

1996 Authorization: Such sums

Purpose and Method of Operations

The Targeted Assistance Program (TAP) provides grants to States for counties which are impacted by high concentrations of refugees and high dependency rates. States are required by statute to pass on to the designated counties at least 95% of the funds awarded.

In addition, Congress has historically directed that a portion of the TAP funds be awarded to address specific impacts, such as increased Cuban and Haitian refugee and entrant arrivals.

In FY 1995, the Office of Refugee Resettlement directed targeted assistance funds to areas with large concentrations of refugee and entrant populations to supplement available services. Services provided by this program are generally designed to secure employment for refugees within one year or less. Of the \$55.4 million available in FY 1995, \$25,457,300 was allocated by formula based on refugee population concentrations. Approximately \$10,939,700 was awarded to 29 States on a competitive basis to address special impact problems. The remaining funds were earmarked by Appropriations Committee report language for communities affected by recent increased arrivals of Cuban and Haitian refugees and entrants.

Included in the FY 1996 Policy level is \$5,000,000 appropriated in the Foreign Operations Appropriation. In accordance with Congressional intent, these funds were used to augment the ten-percent set-aside for grants to localities most heavily impacted by the influx of refugees including Laotian Hmong, Cambodians, and Pentecostals.

¹ Based on levels of the ninth CR, including an incremental policy adjustment and \$5,000,000 for Targeted Assistance appropriated in P.L. 104-107, the Foreign Operations Appropriations Act.

Funding for this program over the past five years has been:

FY 1992.....	48,794,002
FY 1993.....	49,397,000
FY 1994.....	55,397,000 ¹
FY 1995.....	55,397,000
FY 1996 Policy.....	54,397,000

Rationale for the Budget Request

The FY 1997 request for this program is \$49,397,000, a reduction of \$5,000,000 from the 1996 Policy level. The reduction is consistent with earlier levels of support for this activity. The amount requested will be awarded to States to enable counties and other jurisdictions which have high concentrations of refugees to provide needed employment services and to address other impacts resulting from high numbers of refugees.

¹ Includes \$6,000,000 reprogrammed from Transitional and Medical Services.

Refugee Resettlement: Targeted Assistance ¹

Program Data:

	<u>FY 1995 Actual</u>	<u>FY 1996 Policy ²</u>	<u>FY 1997 Request</u>
Service Grants			
Formula	\$25,457,300	\$20,517,600	\$25,457,300
Discretionary	29,939,700	33,879,400	23,939,700
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
Total Program	\$55,397,000	\$54,397,000	\$49,397,000
Number of Applicants	109	93	93
Number of Grants	80	52	52
New Starts:			
#	19	20	20
\$	\$6,129,079	\$2,939,700	\$2,939,700
Continuations:			
#	61	32	32
\$	\$49,267,921	\$51,457,300	\$46,457,300
Contracts:			
#	0	0	0
	\$0	\$0	\$0

¹ In FY 1995, amounts include \$6,000,000 made available under the Foreign Operations Act. Under the FY 1996 Policy level, \$5,000,000 was appropriated by P.L. 104-107.

² Based on levels of the ninth CR, including an incremental policy adjustment and \$5,000,000 for Targeted Assistance appropriated in P.L. 104-107, the Foreign Operations Appropriations Act.

STATE TABLES

REFUGEE AND ENTRANT ASSISTANCE

CASH AND MEDICAL ASSISTANCE AND UNACCOMPANIED MINORS

State	FY 1995 Enacted	FY 1996 Policy	FY 1997 Request
Alabama	\$142,000	\$161,000	\$139,000
Alaska 1/	---	---	---
Arizona	2,316,160	3,280,000	2,824,000
Arkansas	37,541	38,000	33,000
California	60,957,191	52,761,000	45,803,000
Colorado	1,735,979	2,104,000	1,812,000
Connecticut	1,877,635	1,693,000	1,458,000
Delaware	28,141	94,000	81,000
D.C.	1,604,180	2,695,000	2,320,000
Florida	39,300,000	56,362,000	48,528,000
Georgia	5,495,861	5,561,000	4,788,000
Hawaii	1,120,557	558,000	480,000
Idaho	419,334	503,000	433,000
Illinois	8,918,688	8,290,000	7,138,000
Indiana 2/	---	107,000	92,000
Iowa	1,929,573	2,351,000	2,024,000
Kansas	796,632	794,000	684,000
Kentucky 3/	---	---	---
Louisiana 2/	---	662,000	570,000
Maine	237,723	257,000	221,000
Maryland	2,058,861	2,145,000	1,847,000
Mass.	9,389,453	10,483,000	9,026,000
Michigan	4,000,000	3,734,000	3,215,000
Minnesota	3,407,099	6,383,000	5,496,000
Mississippi	770,000	777,000	669,000
Missouri	2,445,240	2,262,000	1,948,000
Montana 2/	---	194,000	167,000
Nebraska	1,099,286	1,221,000	1,051,000
Nevada 3/	---	---	---
New Hampshire	328,941	366,000	315,000
New Jersey	3,729,370	4,476,000	3,854,000
New Mexico	1,100,000	1,550,000	1,335,000
New York	20,058,376	18,532,000	15,956,000
North Carolina	1,000,000	1,021,000	879,000
North Dakota	768,645	1,041,000	896,000

REFUGEE AND ENTRANT ASSISTANCE

CASH AND MEDICAL ASSISTANCE AND UNACCOMPANIED MINORS

State	FY 1995 Enacted	FY 1996 Policy	FY 1997 Request
Ohio	\$3,000,000	\$2,904,000	\$2,500,000
Oklahoma	656,798	797,000	686,000
Oregon	5,187,362	5,023,000	4,325,000
Pennsylvania	5,252,203	5,600,000	4,822,000
Rhode Island	351,381	363,000	313,000
South Carolina	38,538	102,000	88,000
South Dakota	241,423	209,000	180,000
Tennessee	540,909	643,000	554,000
Texas	8,500,000	6,235,000	5,368,000
Utah	1,713,281	2,086,000	1,796,000
Vermont	414,027	393,000	338,000
Virginia	4,824,482	4,451,000	3,832,000
Washington	10,457,487	13,089,000	11,270,000
West Virginia	25,904	5,000	4,000
Wisconsin	1,189,203	1,276,000	1,099,000
Wyoming 1/	---	---	---
Unobligated 4/	9,536,460	---	---
Other 5/	31,271,077	31,269,000	43,245,000
Total, Budget Authority	\$260,273,001	\$266,901,000	\$246,502,000

1/ Alaska and Wyoming no longer participate in the Refugee Resettlement Program.

2/ Indiana, Louisiana, and Montana used only prior year funds to cover FY 1995 actual costs.

3/ Kentucky and Nevada operate under the Wilson/Fish alternative program.

4/ To be used to address FY 1995 unanticipated State costs.

5/ Includes voluntary agency matching grant program, Wilson/Fish alternative program, and evaluation and monitoring activities required under sec. 412(a)(7) of the INA.

REFUGEE AND ENTRANT ASSISTANCE
SOCIAL SERVICES

State	1995 Actual	1996 Policy	1997 Estimate
Alabama	\$133,380	\$125,000	\$125,000
Alaska 1/	75,000	0	0
Arizona	668,638	736,000	736,000
Arkansas	94,113	100,000	100,000
California	15,606,873	14,562,000	14,562,000
Colorado	673,327	704,000	704,000
Connecticut	604,205	573,000	573,000
Delaware	75,000	75,000	75,000
Dist. of Col	325,983	325,000	325,000
Florida	6,736,395	8,476,000	8,476,000
Georgia	1,641,375	1,844,000	1,844,000
Hawaii	166,031	140,000	140,000
Idaho	174,019	201,000	201,000
Illinois	2,374,967	2,380,000	2,380,000
Indiana	199,549	212,000	212,000
Iowa	542,204	639,000	639,000
Kansas	389,720	391,000	391,000
Kentucky 2/	333,103	454,000	454,000
Louisiana	414,382	414,000	414,000
Maine	100,000	134,000	134,000
Maryland	1,401,361	1,189,000	1,189,000
Massachusetts	2,044,121	1,875,000	1,875,000
Michigan	1,355,511	1,458,000	1,458,000
Minnesota	1,648,496	1,819,000	1,819,000
Mississippi	75,000	75,000	75,000
Missouri	919,768	925,000	925,000
Montana	75,000	75,000	75,000
Nebraska	326,504	342,000	342,000
Nevada 3/	183,239	277,000	277,000
New Hampshire	100,556	127,000	127,000

REFUGEE AND ENTRANT ASSISTANCE
SOCIAL SERVICES (continued)

State	1995 Actual	1996 Policy	1997 Estimate
New Jersey	1,409,870	1,386,000	1,386,000
New Mexico	303,405	339,000	339,000
New York	12,347,742	11,301,700	11,301,700
North Carolina	533,868	597,000	597,000
North Dakota	199,723	193,000	193,000
Ohio	1,056,100	943,000	943,000
Oklahoma	240,015	251,000	251,000
Oregon	1,028,486	1,000,000	1,000,000
Pennsylvania	1,930,540	1,824,000	1,824,000
Rhode Island	164,120	121,000	121,000
South Carolina	100,000	100,000	100,000
South Dakota	132,859	121,000	121,000
Tennessee	595,174	640,000	640,000
Texas	3,133,393	3,098,000	3,098,000
Utah	279,438	327,000	327,000
Vermont	127,302	133,000	133,000
Virginia	1,057,316	1,123,000	1,123,000
Washington	3,373,581	3,520,000	3,520,000
West Virginia	75,000	75,000	75,000
Wisconsin	1,040,470	942,000	942,000
Wyoming 1/	75,000	0	0
Discretionary 4/	16,140,778	12,120,300	12,120,300
Total, Budget Authority	\$84,802,000	\$80,802,000	\$80,802,000
1/ Alaska and Wyoming have withdrawn from the Refugee Resettlement program.			
2/ Kentucky operates under an alternative program.			
3/ Nevada operates under an alternative program.			
4/ Includes Program Support.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Violent Crime Reduction Programs

<u>FY 1997 Budget</u>	<u>Page</u>
Appropriation language and explanation of language changes.	K-2
Amount available for obligation	K-3
Summary of changes	K-4
Budget authority by activity	K-5
Budget authority by object	K-6
Authorizing legislation	K-7
Appropriation history table	K-10
Justification:	
A. General Statement.	K-11
B. Community Schools Youth Services and Supervision .	K-12
C. Battered Women's Shelters.	K-15
D. Domestic Violence Hotline.	K-18
State Tables	K-20

Violent Crime Reduction Programs

For activities authorized by sections 30401, 40211, and 40241 of Public Law 103-322, \$29,000,000, to remain available until expended, which shall be derived from the Violent Crime Reduction Trust Fund, of which \$13,600,000 shall be for the Community Schools Youth Services and Supervision Grant Program; \$15,000,000 for grants for Battered Women's Shelters; and \$400,000 for the National Domestic Violence Hotline.

Note. A regular 1996 appropriation for this account had not been enacted at the time this budget was prepared. The 1996 amounts included in this budget are based on the levels provided in three continuing resolutions: P.L. 104-91, P.L. 104-92, and P.L. 104-99.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families

Violent Crime Reduction Programs

Amounts Available for Obligation

	1995 <u>Actual</u>	1996 <u>Policy a/</u>	1997 <u>Estimate</u>
Appropriation	---	---	---
Real transfer from:			
Department of Justice			
Violent Crime Trust			
Fund	\$11,000,000	\$13,300,000	\$29,000,000
Comparative transfer			
from:			
Children and Families			
Services account for			
the Youth Gang Drug			
Prevention Program	<u>10,420,000</u>	<u>---</u>	<u>---</u>
Subtotal, adjusted			
budget authority	\$21,420,000	\$13,300,000	\$29,000,000
Total Obligations	\$21,420,000	\$13,300,000	\$29,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

SUMMARY OF CHANGES

1996 Policy	\$13,300,000
1997 Estimate	<u>\$29,000,000</u>
Net Change	+\$ 15,700,000

	FY 1996 <u>Policy a/</u>	<u>Change from Base</u>
Increases:		
A. <u>Program:</u>		
1. Increase in the Community Schools Youth Services and Supervision Program	\$7,900,000	+\$5,700,000
2. Increase in the Grants for Battered Women's Shelters	5,000,000	+\$10,000,000
Total increases		+\$15,700,000
Net Change		+\$15,700,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

Violent Crime Reduction Programs

Budget Authority by Activity

	1995 <u>Actual</u>	1996 <u>Policy a/</u>	1997 <u>Estimate</u>
Community Schools			
Youth Services			
and Supervision ..	\$10,000,000	\$7,900,000	\$13,600,000
Youth Gang Drug			
Prevention	<u>10,420,000</u>	<u>---</u>	<u>---</u>
Subtotal, Community			
Schools Youth			
Services and			
Supervision	20,420,000	7,900,000	13,600,000
Grants for Battered			
Women's Shelters	---	5,000,000	15,000,000
Domestic Violence			
Hotline	<u>1,000,000</u>	<u>400,000</u>	<u>400,000</u>
Total, budget			
authority	\$21,420,000	\$13,300,000	\$29,000,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

Violent Crime Reduction Programs

Budget Authority by Object

	FY 1996 <u>Policy a/</u>	FY 1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Other Services.	---	1,340,000	+1,340,000
Grants, subsidies and contri- butions	<u>\$13,300,000</u>	<u>\$27,660,000</u>	<u>+\$14,360,000</u>
Total, budget authority by object	\$13,300,000	\$29,000,000	+\$15,700,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

Violent Crime Prevention Programs

Authorizing Legislation

<u>Activity</u>	1996 Amount <u>Authorized</u>	1996 Policy	1997 Amount <u>Authorized</u>	1997 Estimate
1. Community Schools Youth Services and Supervision Grants (Sec. 30403 (a) of the Violent Crime Control and Law En- forcement Act)	\$72,450,000	\$7,900,000	\$85,050,000	\$13,600,000
2. Grants for Battered Women's Shelters (Sec. 310 (a) of the Family Violence Prevention and Services Act, as amended)	a/	5,000,000	a/	15,000,000
3. National Domestic Violence Hotline (Sec. 316 (f) of the Family Violence Prevention and Services Act, as amended)	400,000	400,000	400,000	400,000
Total Appropriation..		\$13,300,000		\$29,000,000
Total Appropriation Against Definite Authorization		13,300,000		29,000,000

K-7

Authorizing Legislation

<u>Activity</u>	1996 Amount Authorized	1996 Policy	1997 Amount Authorized	1997 Estimate
<u>Unfunded Authorities</u>				
1. Community Economic Partnership Invest- ment and Improvement Grants (Sec. 31132 (a) of the Violent Crime Control and Law Enforcement Act]	27,000,000	---	43,200,000	---
2. Education and Pre- vention Grants to Reduce Sexual Abuse of Runaway, Homeless, and Street Youth (Sec. 316 (c) of the Runaway and Homeless Youth Act, as amend- ed]	7,000,000	---	\$8,000,000	---

Authorizing Legislation

Activity	1996 Amount <u>Authorized</u>	1996 Policy	1997 Amount <u>Authorized</u>	1997 <u>Estimate</u>
<u>Unfunded Authorities</u>				
3. Youth Education and Domestic Violence [Sec. 317 (d) of the Family Violence and Prevention Ser- vices Act, as amend- ed]	400,000	---	not authorized	---

a/ Total authorization for the Act is \$60,000,000. Of the total \$32,619,000 is requested in the Children and Families Services account and \$15,000,000 is requested in this account.

APPROPRIATION HISTORY TABLE

Violent Crime Prevention Programs

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1995	---	---	---	\$11,000,000
1996	\$105,300,000	800,000	25,900,000 ^{a/}	^{b/}
1997	29,000,000			

^{a/} This is Senate Committee action.

^{b/} The FY 1996 Policy level for this account is \$13,300,000.

Justification
Violent Crime Prevention Programs

	1996 <u>Policy a/</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Community Schools Youth Services and Supervision	\$7,900,000	\$13,600,000	+\$5,700,000
Grants for Battered Women's Shelters ..	5,000,000	15,000,000	+10,000,000
Domestic Violence Hotline	400,000	400,000	---
Total, budget authority	\$13,300,000	\$29,000,000	+\$15,700,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

General Statement

The Violent Crime Control and Law Enforcement Act of 1994 is a sweeping measure, strengthening virtually every approach to fighting crime across the nation. The Violent Crime Prevention Programs in this account are a response to help balance crime prevention and law enforcement efforts in communities. They include programs in the community that will focus on before-and after-school activities, and shelter and services to victims of domestic violence, including battered women.

The President's appropriation request of \$29,000,000 for this account represents current law requirements. No proposed law amounts are included.

Community Schools Youth Services and Supervision

Authorizing Legislation - Section 30403 (a) of the Violent Crime Control and Law Enforcement Act.

<u>FY 1995</u> <u>Actual</u>	<u>FY 1996</u> <u>Policy a/</u>	<u>FY 1997</u> <u>Request</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$20,419,523	\$7,900,000	\$13,600,000	+\$5,700,000

a/ Based on levels of the ninth CR, including an incremental policy adjustment.

FY 1997 Authorization..... \$85,050,000

Purpose and Method of Operations

The Community Schools Youth Services and Supervision Grants will be consolidated with the Youth Gang Drug Prevention Program in FY 1997. The single program will provide discretionary grants to non-profit community-based organizations that form local consortium of service providers.

Funds may be used for academic tutoring and mentoring programs that are offered after school and on weekends and holidays during the school year and as daily full- or part-day programs during the summer months. Programs may include curriculum-based supervised educational activities, work force preparation and entrepreneurship activities. Funding will go to serve areas with significant poverty and juvenile delinquency.

If the appropriation for the program exceeds \$20 million in the fiscal year, then the funds are allocated among the States on the basis of comparative numbers of children in poverty. The Secretary then awards grants to community-based organizations within each State on a discretionary basis from the State's allocation. If the annual appropriation is less than \$20 million, the Secretary awards grants on a competitive basis to community-based organizations throughout the nation. In awarding grants, the Secretary of HHS shall give priority to community-based organizations that demonstrate the greatest effort in generating local support for programs.

The Federal share of program costs is 75 percent in FY 1995 and FY 1996, 70 percent in FY 1997 and 60 percent in FY 1998 and thereafter. The non-Federal share may be cash or in-kind, with at least 15 percent coming from private non-profit sources.

FY 1997 will be the third year of this program. Funding has been as follows:

1995 Comparable...	\$20,419,523
1996 Policy	7,900,000

Rationale for the Budget Request

The FY 1997 request for Community Schools Youth Services and Supervision Grants is \$13,600,000, an increase of \$5,700,000 over the FY 1996 policy level. The FY 1997 request consolidates the Youth Gang Drug Prevention program with the Community Schools Program. Both of these programs provide community-based, comprehensive services to youth.

In FY 1997 these funds will provide youth constructive opportunities for positive, healthy development and develop family and community supports for those youth. Activities will include tutoring, mentoring, work force preparation, and entrepreneurial activities.

Partly as a result of widespread concern about youth crime and other bad outcomes among youth (dropping out of high school, too-early childbearing), communities across the country are interested in the opportunity to try out new, collaborative approaches to youth development. The consolidated youth development program would enable us to promote comprehensive and innovative planning and service delivery at the community level, to reduce administrative burden, and to support a variety of different approaches to youth development that meet the needs of individual communities.

Name of Program: Community Schools Grant Program

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants			
Formula	--	--	--
Discretionary	\$9,000,000	\$7,900,000	\$12,260,000
Research	--	--	--
Demonstration	--	--	--
Development	--	--	--
Training/Technical Assistance	--	--	500,000
Evaluation	--	--	500,000
Program Support	--	--	--
Other <u>1/</u>	1,000,000	--	340,000
 Total Program	 \$10,000,000	 \$7,900,000	 \$13,600,000
Number of Applicants	680	100	100
Number of Grants	35	48	55
New Starts:			
#	48	--	--
\$	9,000,000	--	--
Continuations:			
#	--	48	55
\$	--	7,900,000	12,260,000
Contracts:			
#	1	--	3
\$	1,000,000	--	1,340,000

1/ Includes costs of program reviews, printing and administrative costs.

Grants for Battered Women's Shelters

Authorizing Legislation - Section 310(a) of the Family Violence Prevention and Services Act, as amended.

<u>FY 1995</u> <u>Actual</u>	<u>FY 1996</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
---	\$5,000,000	\$15,000,000	+\$10,000,000

FY 1997 Authorization..... a/

a/ The authorization for the Act is \$60,000,000. Of that amount, \$15,000,000 is requested in this account and \$32,619,000 is requested in the Children and Families Services account.

Purpose and Method of Operations

The Grants for Battered Women's Shelters program is a formula grant program. Grants are made to State agencies designated by the Governor and Indian tribes.

States must give special emphasis to the support of community-based projects of demonstrated effectiveness, the primary purpose of which is to operate shelters for victims of family violence and their dependents. In addition, emphasis is given to projects which provide counseling, advocacy and self-help services to victims and their children.

State domestic violence coalitions and others must be involved in the decisions to ensure an equitable distribution of funds throughout the State.

No income eligibility standard may be used as a condition for receipt of services.

Rationale for the Budget Request

The FY 1997 request for the Grants for Battered Women's Shelters program is \$15,000,000, an increase of \$10,000,000 over the FY 1996 policy level. As part of the Violence Against Women Act, these funds along with funds in the Children and Families Services account will provide immediate shelter and related assistance to victims of family violence and their dependents. These funds also will be used to increase public awareness and prevent family violence.

Statistics indicate the severity of the problem. Some experts estimate that a woman has between a 1-in-3 and a 1-in-5 chance of being physically assaulted during her lifetime; total domestic violence, reported and unreported, affects as many as 4 million women a year ("Violence Against Women, A Majority Staff Report", Committee on the Judiciary, United States Senate, 103rd Congress, October 1992, p. 3, citing the American Medical Association and Dr. Angela Browne, respectively). In addition, approximately 2.4 million children are abused by their parents each year.

Name of Program: Grants for Battered Women's Shelters

Program Data:

	<u>FY 1995 Enacted</u>	<u>FY 1996 Policy</u>	<u>FY 1997 Request</u>
Service Grants:			
Formula	---	4,750,000	\$13,750,000 <u>1/</u>
Discretionary		125,000	625,000
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	125,000	625,000 <u>2/</u>
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	---	\$5,000,000	\$15,000,000 <u>3/</u>
Number of Grants			220
New Starts:			
#		220	220
\$		5,000,000	15,000,000
Continuations:			
#			
\$			
Contracts:			
#			
\$			

1/ Formula grant allocation: \$10,000,000 to States for shelter grants; \$2,500,000 to State Domestic Violence Coalitions; \$1,250,000 to Indian Tribes for shelter grants.

2/ National Resource Centers on Domestic Violence and three affected Special Issue Rescue Centers.

3/ OGC has advised that the Grants for Battered Women's Shelters Program dollars must be allocated as per the allotment requirements in the Family Violence Prevention Services Act.

Domestic Violence Hotline

- Authorizing Legislation - Section 316(f) of the Family Violence and Prevention and Services Act, as amended.

<u>FY 1995</u> <u>Actual</u>	<u>FY 1996</u> <u>Policy</u>	<u>FY 1997</u> <u>Request</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$1,000,000	\$400,000	\$400,000	---

FY 1997 Authorization..... \$400,000

Purpose and Method of Operations

The National Domestic Violence Hotline is a cooperative agreement which will fund, for up to five years, the operation of a national, toll-free telephone hotline to provide information and assistance to victims of domestic violence. Counseling and referral services will be provided 24 hours-a-day, 365 days a year. The hotline must also publicize the number and services available to potential users throughout the United States.

Funding since the beginning of the program has been:

1995	\$1,000,000
1996	400,000

Rationale for the Budget Request

The FY 1997 request for the Domestic Violence Hotline is \$400,000, the full amount authorized. This is the same as the FY 1996 policy level.

The hotline became operational February 20, 1996. The hotline provides information and assistance to victims of domestic violence on a 24 hour-a-day, 365 days-a-year basis. A database is maintained that provides information on services for victims of domestic assistance, including the availability of shelters, to which callers may be referred throughout the United States.

Trained hotline counselors are available for non-English speakers and the hotline is accessible to persons who are hearing-impaired.

Name of Program: Domestic Violence Hotline

Program Data:

	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Service Grants:			
Formula	---	---	---
Discretionary	\$1,000,000	\$400,000	\$400,000
Research	---	---	---
Demonstration	---	---	---
Development	---	---	---
Training/Technical Assistance	---	---	---
Evaluation	---	---	---
Program Support	---	---	---
Other	---	---	---
TOTAL PROGRAM	\$1,000,000	\$400,000	\$400,000
Number of Applicants	5	5	5
Number of Grants	1	1	1
New Starts:			
#	1	1	1
\$	1,000,000	400,000	400,000
Continuations:			
#	---	---	---
\$	---	---	---
Contracts:			
#	---	---	---
\$	---	---	---

STATE TABLES

Grants For Battered Women's Shelters

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
Alabama	\$ - 0 -	\$ 34,586	\$ 174,590
Alaska		25,000	125,000
Arizona		33,406	168,631
Arkansas		25,000	125,000
California		257,683	1,300,686
Colorado		29,971	151,292
Connecticut		26,848	135,525
Delaware		25,000	125,000
D.C.		25,000	125,000
Florida		114,385	577,401
Georgia		57,836	291,949
Hawaii		25,000	125,000
Idaho		25,000	125,000
Illinois		96,341	486,319
Indiana		47,154	238,028
Iowa		25,000	125,000
Kansas		25,000	125,000
Kentucky		31,373	158,368
Louisiana		35,373	178,562
Maine		25,000	125,000
Maryland		41,038	207,157
Mass.		49,523	249,987
Michigan		77,847	392,962
Minnesota		37,439	188,991
Mississippi		25,000	125,000
Missouri		43,268	218,413
Montana		25,000	125,000
Nebraska		25,000	125,000
Nevada		25,000	125,000
New Hampshire		25,000	125,000

State	FY 1995 <u>Enacted</u>	FY 1996 <u>Policy</u>	FY 1997 <u>Request</u>
New Jersey	- 0 -	64,796	327,082
New Mexico		25,000	125,000
New York		148,947	751,867
North Carolina		57,959	292,569
North Dakota		25,000	125,000
Ohio		91,013	459,421
Oklahoma		26,708	134,822
Oregon		25,298	127,704
Pennsylvania		98,801	498,734
Puerto Rico		25,000	125,000
Rhode Island		25,000	125,000
South Carolina		30,037	151,623
South Dakota		25,000	125,000
Tennessee		42,424	214,151
Texas		150,661	760,516
Utah		25,000	125,000
Vermont		25,000	125,000
Virginia		53,712	271,134
Washington		43,801	221,103
West Virginia		25,000	125,000
Wisconsin		41,661	210,302
Wyoming		25,000	125,000
Territories		35,111	85,111
Coalitions		2,500,000	2,500,000
Total	- 0 -	\$5,000,000	\$15,000,000

THURSDAY, MAY 2, 1996.

ADMINISTRATION ON AGING

WITNESSES

FERNANDO M. TORRES-GIL, ASSISTANT SECRETARY FOR AGING, ADMINISTRATION ON AGING

WILLIAM F. BENSON, DEPUTY ASSISTANT SECRETARY, OFFICE OF GOVERNMENTAL AFFAIRS AND ELDER RIGHTS

JOHN F. McCARTHY, DIRECTOR, OFFICE OF MANAGEMENT

EDWIN L. WALKER, DIRECTOR, OFFICE OF PROGRAM OPERATIONS AND DEVELOPMENT

DENNIS P. WILLIAMS, DEPUTY ASSISTANT SECRETARY FOR BUDGET, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MILLER. Welcome, Mr. Torres-Gil.

Mr. TORRES-GIL. Thank you, Mr. Chairman.

Mr. MILLER. Please introduce your guests with you, and proceed.

INTRODUCTION OF WITNESSES

Mr. TORRES-GIL. Thank you. To my left is our Deputy Assistant Secretary on Aging, your right, Bill Benson, who handles intergovernmental affairs and elder rights. To my right is Edwin Walker, who is the Director of program operations. To his right is Jack McCarthy, Director of our Office of Management.

OPENING STATEMENT

I will summarize my testimony for the record. Let me thank all of you for the opportunity to present the fiscal year 1997 budget request for the Administration on Aging. We're quite proud of the work and the services that we provide through the Older Americans Act, and through the aging network of the Administration on Aging.

Our fiscal year 1997 budget request is for \$828 million which is approximately 5 percent below the 1995 level. Although we recognize that our population of older persons is growing, we also recognize that fiscal resources are limited. So we feel this is a realistic budget request which allows us to continue the important services of the Older Americans Act in a way that continues to serve older persons and their families.

TARGETING

Our budget in particular will be targeted to the most vulnerable of older persons, including those most likely to be frail, who are low income, minority, and those who are economically disadvantaged. The overall purpose of our budget and our services is to give older persons the opportunity, and the choice, to stay in their homes, in

their communities, with the assistance of the programs that we provide.

We know that there are some demographic pressures facing us. We now serve, at this point, through the Older Americans Act, approximately 33 million persons. The Older Americans Act is available to anyone 60 years of age and over. In 20 to 30 years, there will be twice as many older Americans.

So while we try to serve and make good use of our dollars today, we are also looking to the future. A number of our funding requests are to allow us to plan ahead for what will be an even greater level of need and a population group that we are chartered to serve.

AGING NETWORK

We are able to, I think, perform our services well because we rely primarily on what we call an aging network, which is a system of 57 state units on aging. Approximately 300 tribes are served through our 221 grantees. We have 670 area agencies on aging, more than 27,000 service providers and 6,000 senior centers. So we're also, I think, quite proud of the fact that we're essentially a bottom up program, where most, practically all, the dollars go to the local services, where they directly benefit older persons and their families.

HOME AND COMMUNITY-BASED SERVICES

To give you some examples of the kinds of services we provide and how we reach out to older Americans, last year we provided over 240 million meals, 40 million rides for physicians and pharmacy visits, nearly 10 million personal care services, and 700,000 reassuring visits. And so we are able to serve this population of older persons in ways that are very important to their ability to stay home and stay in their communities.

We are also, however, trying to streamline how the Federal Government as a whole serves this growing population of older Americans, recognizing that we may never have all the dollars that we need, and that we at the Federal level have to be more efficient in how we coordinate our services.

CONSOLIDATION

So as part of the reauthorization of the Older Americans Act, we are proposing to transfer the elderly nutrition program from the Department of Agriculture to the Administration on Aging, which will allow us to reduce much of the bureaucratic red tape that goes by along with having two separate programs. That would mean ultimately a transfer of about \$150 million to the AOA budget.

We're also planning to transfer the Department of Labor's senior community services employment program—known as Title V of the Older Americans Act—to the Administration on Aging. That would bring over an additional \$350 million for that program. Both of those transfers are in the reauthorization legislation which was reported out by the House Economic and Educational Opportunities Committee on March 14.

ELDER RIGHTS

Before I go into any specifics, Mr. Chairman, I'd like to highlight two programs that I think are examples of how we serve older Americans and support these community based programs. For example, Title VII, for which we are asking for funding, provides critical services in the Long Term Care Ombudsman program, as well as elder abuse prevention and the benefit insurance and pension counseling programs. One of the objectives of the Administration on Aging is to serve the most vulnerable, those who are more likely to be either forgotten or who are not served by other Federal agencies.

In the case of the Long Term Care Ombudsman program, we work through state ombudsmen and thousands of volunteers to ensure that older persons in nursing homes, assisted living facilities, and board and care facilities are protected and that they have someone to represent their interests and rights.

Through our pension and benefit counseling program, we provide services to older persons so that they can get through the confusing maze of different Federal programs and the eligibility criteria that go with them. This is another example under Title VII where we feel our fiscal year 1997 budget will allow us to continue to fund critical programs.

We are also requesting, I might add, monies for our program administration. Although we have quite a large aging network, all of these programs are overseen by a relatively small staff at the Federal headquarters and regional offices, approximately 177 persons work in our regional offices and in headquarters. It is their job to provide the oversight and accountability, the technical assistance, and to make sure that these various programs are run well.

TRAINING, RESEARCH AND DEMONSTRATION

Lastly, I might highlight Title IV of the Older Americans Act. Title IV is our applied research demonstration and development program. It provides the funds that allow us to develop innovative ways to serve older Americans, to serve them more efficiently, and to meet the growing trends that are affecting an aging population.

For example, we have funded in the past the development of area agencies on aging, the nutrition programs such as "meals on wheels," and a host of other services, such as case management. Today we're funding, for example, Resource Centers for Native American elders, a national center on elder abuse, and several centers for long term care. We are also working with the states with these dollars to help them expand and to better integrate their programs for older Americans with disabilities, as well as younger Americans with disabilities.

This Title IV program, we believe, is an important service that the Administration on Aging provides to prepare this country for its own aging, and to make the best use of the limited dollars. So the overall budget, Mr. Chairman, allows us to continue to fund all our major services, whether they are nutrition, supportive services, or ombudsman programs. It allows us to continue with our small staff to ensure that we provide services efficiently. And it provides

funds for important investments through our Title IV program for what will be dramatic changes in the demographics of this country.

And so with that, Mr. Chairman, I'm happy to respond to any questions that you may have.

Thank you.

[The prepared statement of Mr. Fernando Torres-Gil follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Statement by the Assistant Secretary on Aging

Mr. Chairman and members of the Subcommittee:

I appreciate this opportunity to discuss with you today the Fiscal Year (FY) 1997 budget request for the Administration on Aging (AoA).

Our FY 1997 budget request is \$828 million, the same level as the comparable FY 1996 amount which is based on the ninth Continuing Resolution (P.L.104-99) with incremental policy adjustments, and about five percent below the FY 1995 enacted level. At a time of fiscal austerity, this request provides funds for programs aimed at improving the quality of life of older Americans and families, in particular those individuals who are vulnerable, who have physical and cognitive impairments that put them at risk of institutionalization, and at helping them remain independent and productive.

I strongly believe that the request we are presenting today is a solid one in spite of budget constraints. It is built on careful planning as to how we might make the greatest use of Federal funds if we are to meet the needs of the nation's burgeoning elderly population. AoA serves older persons and their families within the framework of the Older Americans Act. As the focal point in the Federal Government for serving older persons, AoA works to advance dignity and independence of older Americans. The service delivery levels funded by the Administration on Aging will be maintained in FY 1997 and targeted to the needs of socially and economically disadvantaged older persons, especially the low-income and minority elderly.

By the year 2030, it is estimated that the number of people aged 60 and older will increase to 89 million, representing 25% of the total population, while those 85 and older will increase to almost 9 million. AoA recognizes the need to address these demographic changes. Thus, our focus is not just on reaffirming our commitment to serving today's older persons, but also on working toward a secure and productive future for the elderly of the 21st century.

Briefly summarized, our FY 1997 budget request will provide funding for the support of a network of 57 State units on Aging, 221 grantees representing over 300 tribes, 670 Area Agencies on Aging, and more than 27,000 service providers including 6,000 senior centers throughout the country; provide over 240 million meals -- about half of meal recipients are low-income elders and 17 percent of recipients are members of minority groups; provide supportive services, including over 40 million rides for physician and pharmacy visits, nutrition and related activities, over 12 million responses for information and referrals and access to vital services for seniors and their families, nearly 10 million personal care services to elderly in need and about one million legal counseling sessions; and support services for the frail elderly, including an additional 1.3 million personal care services, 700,000 reassuring visits and telephone calls, over 150,000 complaints concerning nursing homes are resolved by Long-Term Care Ombudsman programs.

The Administration has proposed reauthorizing legislation for the Older Americans Act that includes transfer of \$150,000,000 from the Department of Agriculture to AoA to administer functions of the Department of Agriculture's Nutrition Program for the Elderly. In addition, the reauthorization legislation includes \$350,000,000 to administer the Department of Labor's Community Service Employment program for Older Americans. The Older Americans Act reauthorization legislation passed by the House Educational and Economic Opportunities Committee supports both of these actions.

It is important to note that AoA and the National Network on Aging not only provide services but also must act to protect the rights and safety of older people, especially those who are vulnerable. The Title VII programs: Long-Term Care Ombudsmen, elder abuse protection, and benefits insurance and pension counselling help ensure that older persons are protected and their rights are not abridged. The limited funding for these programs allows State Agencies on Aging to provide for these services.

The ombudsmen program is one of the most effective programs for protecting the most vulnerable older people, those who must live in nursing or board and care homes. Elder abuse has well been documented as a major problem for many older people. The Title VII Elder Abuse Prevention program provides support for helping abused and exploited older people.

The benefits and pension counselling program while small has established itself by helping older people receive the benefits they have earned. No other federal program provides assistance to those older people with pension problems.

For the Federal Administration activity, the amount requested will support 177 full-time equivalent positions and related expenses. This relatively small staff of AoA is responsible for overseeing the national network of 57 State units on Aging, more than 300 Indian tribal organizations, 670 area agencies on aging and more than 27,000 service providers throughout the country. In keeping with the Department's downsizing efforts, we have kept our staffing requirements to a minimum level. We will also continue implementation of the Information Resources Management plan to establish AoA's Information Resources Management infrastructure and maintain the data base for all program information activities. Proper implementation of this plan will ultimately improve the quality of information and service to the public.

Under the mandate of the Title IV program, the Administration on Aging (AoA) has had the resources to emulate the private sector with an applied research, demonstration, and development strategy that develops, tests, and incorporates new ideas and innovative best practices at the state and local levels. As the applied research and development program of the aging network, Title IV has been and continues today as the testing ground for nutrition programs, home care services, legal assistance, transportation, respite care, adult day care, reverse mortgages, and many other innovative services which were funded in order to determine how effectively they would improve the independence, care, and dignity of older Americans in their communities.

The fiscal year 1997 request for Training, Research and Discretionary activities is \$11,666,000. The FY 1997 request is a decrease of over 50% from the Title IV budget levels of prior years, which were in the range of \$25-\$26 million during the first half of this decade. The lower request for AoA's discretionary program reflects our realistic understanding of contemporary budget realities as well as the greater priority on providing services to the elderly under Older Americans Act programs.

However, this does not lessen the importance of investing in this vital discretionary program in preparing the nation for a doubling of the older population. Title IV remains critical to determining how best to serve older persons and their families, now and in the 21st century, through applied research, innovative model programs, better trained personnel, and timely technical assistance and information.

Principal current examples of Title IV initiatives include: the National Resource and Policy Centers in long-term care, nutrition, long-term care ombudsman, elder abuse prevention, housing, and older women; a National Aging Information Center; a National Academy on Aging; two National Resource Centers on Native

American Elders; and career preparation programs in the field of aging. The following program priorities will guide the allocation of FY 1997 Title IV funds:

- 1) Expanding the current system of consumer directed home and community-based long-term care for older persons and others with disabilities, with a special emphasis on Alzheimer's Disease victims and their caregivers;
- 2) Developing a blueprint for the retirement of the baby-boom generation;
- 3) Protecting older persons from crime, violence, abuse, and exploitation; and
- 4) Advancing our understanding of how to better serve the elderly, including minorities.

The mission of the Administration on Aging is to ensure that present and future older Americans have an independent, productive, healthy and secure life. This budget request will greatly support the cornerstone of comprehensive and coordinated home and community-based services which are needed to make the provisions of the Older Americans Act a reality in local communities across the nation. Our request will also continue to build on the foundation of enhancing AoA's ability to meet its vision, and to continue to be responsive and effective in serving our consumers.

Thank you, Mr. Chairman. My colleagues and I will be happy to answer any question which you and the members of the Subcommittee may have.

Mr. MILLER. Thank you.

REAUTHORIZATION

The reauthorization expired as of last year, is that right?

Mr. TORRES-GIL. As of September 30, 1995, yes, sir.

Mr. MILLER. Right. And so do you expect it will go through this year? Give me a status report.

Mr. TORRES-GIL. Certainly. As I mentioned earlier, the authorizing committee in the House has marked up a bill and reported it out. We don't know exactly when it might be voted upon on the Floor of the House, although we keep hearing perhaps in the spring, maybe in the summer. The Senate authorizing committee has not yet marked up their version of the Older Americans Act. They've had several postponements in the markup session. They attempted yesterday and they're going to attempt today to try to resolve some issues and disagreements that have surfaced.

So we don't know, Mr. Chairman, exactly when. We are ready to move quickly once the Congress decides. The Administration submitted its proposed reauthorization some six months ago. [CLERK'S NOTE.—Subsequent to the hearing, AOA corrected this to "ten" for the record.] We have been working closely with the staff and members on both Houses to try to get as much bipartisan agreement in the reauthorization. But at this moment, the House has acted, although they're waiting for a floor vote, and the Senate is still attempting to mark up their version.

Mr. MILLER. When the authorization expired, the appropriation process continued.

Mr. TORRES-GIL. That's correct.

Mr. MILLER. It's not unusual in Government up here for there to be lots of unauthorized programs, as you know.

Mr. TORRES-GIL. It's happened before with the Older Americans Act. We hope it will get done soon, though.

Mr. MILLER. Yes, I know you would prefer to have it done.

You work closely with the state agencies on aging, I guess?

BOTTOMS-UP PLANNING

Mr. TORRES-GIL. That is correct. We have what we believe is a unique and valuable Federal, state, and local partnership. Unlike some of the programs you've heard about earlier, our older Americans Act program essentially is decentralized. We require each area state Office on Aging and area agency on aging to develop a State and area plan. And within those broad parameters and the requirements of the law, we allocate the dollars to each state which in turn then allocates them to area agencies on aging, and each territorial office.

That provides tremendous discretion and flexibility to meet unique local and state needs. Our job, of course, at the top, is to ensure that there is some national accountability. That way we can oversee what is occurring, and we can report back to you about the impact and the successes or the need to modify certain programs.

STATE OF FLORIDA

Mr. MILLER. Last year we had a bad experience in Florida with the agency on aging in Tallahassee. They sent out a letter saying that because the authorization was going to expire on October 1, there would be no more money, and you need to prepare to close down your program.

It was scare tactics, and it was unfortunate. People said, "oh, my gosh," we're going to close down our meals on wheels, we're going to close down our day care program or something. Just because the authorization expired on September 30, when the reality of it up here is, that it is not an unusual experience, and it continues.

But it always bothers me, the scare tactics. I don't know what caused it. You didn't think anybody was going to shut down on October 1 because of lack of authorization, did you?

Mr. TORRES-GIL. No, certainly, it was not the lack of authorization that I think created concern among so many of our providers. Because it's happened before.

Mr. MILLER. Right.

Mr. TORRES-GIL. And previous authorizations were for three, six, even nine months. My sense is that they might have responded down the line when there were continuing resolutions. Then the Government shutdown, I know, created concern among some of our providers.

Mr. MILLER. No, this was a letter from Mr. Lipscomb.

Mr. TORRES-GIL. Bentley Lipscomb. He is the director of the Florida Department on Elder Affairs.

Mr. MILLER. This is written about the current version of the Older American Act expiring on September 30, and authorization ceasing. "Without reauthorization money, this department cannot guarantee payment or reimbursement. There is a possibility we may act," meaning, you know, your staff. But it also says, "we're going to continue to work even though we're not going to be authorized."

And I don't know if it's a lack of communication from here down there, or why this was, but it caused unnecessary concerns. The issue of appropriation is another issue. But this is funded, too, right?

Mr. TORRES-GIL. That's correct.

Mr. MILLER. That was an unfortunate situation in my state, and I don't know why this happened, but it was totally unnecessary.

CONSOLIDATIONS

Initially, what we've been talking about with different agencies is the whole issue of consolidation, because of overlapping and duplication of programs. What is being done to consolidate programs in AOA, especially small programs? I know there's a number of small programs that were not funded this year. These small programs are ones, when you get them down below \$5 million, and you start distributing it to the states, there's not very much money to go around. You say, wait a minute, is this really necessary for a Federal program, why don't they consolidate.

Especially since we did zero out some of these very small ones, but you still want them funded. What is your opinion about the

consolidation, or what are you doing in that effort? I guess it's part of the authorization too.

Mr. TORRES-GIL. We support, we certainly support consolidating programs where it makes sense. One of the historical oddities of Federal programs for the elderly is that they have grown up separately from each other, and they are scattered throughout many other Cabinet departments. Mr. Benson has been responsible for this aspect of looking at the different programs to see where it makes sense to bring them together.

We were charged by both the Vice President, under his reinventing Government initiatives, and by HHS Secretary Donna Shalala, to meet with Cabinet agencies to see where it made sense, where it would save money or streamline, and ultimately best serve families and older persons, because that's ultimately our litmus test for how well we do. From that, we concluded that at least early on, we could bring over the nutrition programs from Agriculture, and the senior community services Employment Program from DOL.

In addition, for example, within HHS, we have some very important but relatively small Alzheimer's demonstration grants. We're also going to bring those over to the Administration on Aging. Then we are also meeting with other departments, such as HUD or DOT, to see where it makes sense. It's certainly not about growing, but rather, is there a value added to bring them together.

So I believe we've made great progress in that. Depending on when the reauthorization occurs, we will actually start doing that.

Mr. MILLER. Well, it makes lots of sense. I commend you for that. As you heard earlier, HHS is talking about a new teenage pregnancy program, even though there's a lot of other programs like that in other agencies. So it's good to be able to consolidate, whether it's from the Department of Agriculture or Department of Labor, together. It certainly makes a lot of sense.

Mr. TORRES-GIL. If I may add, Mr. Chairman, we don't want to do this as a unilateral Federal initiative. In fact, much of the ideas for this consolidation have come from the states, the state offices, the Area Agencies on Aging, the consumers, and governors. The early suggestions of consolidating aging programs came from the National Governors Association. Many states are doing just that, and are finding that it makes sense. So we're hoping to also serve the states well by moving in this direction.

NUTRITION SERVICES

Mr. MILLER. Let me talk about nutrition programs, not the ones in Agriculture. These are the home delivered and the congregate meals. Those are two separate programs, is that right?

Mr. TORRES-GIL. That is correct. They both fall under one general category, but we do provide separate funding for congregate meals and home delivered meals, yes, sir.

Mr. MILLER. I have a very large number of seniors in my district.

Mr. TORRES-GIL. Yes.

Mr. MILLER. Sarasota, Bradenton, Florida, in fact the largest number of seniors in any Congressional district in the country.

Mr. TORRES-GIL. You are the future. [Laughter.]

Mr. MILLER. It is a delightful area to represent. And we do have some excellent programs within the community that get a lot of the

funding through this agency, the senior center in Sarasota and the meals on wheels programs. It's interesting comparing them from community to community. We have an excellent meals on wheels program because it started many years ago in Manatee County, for example.

But then in Sarasota, we have the senior centers which is a great program that Brother Guinan started a number of years ago. I don't know if you know him or not. But at any rate, a big success.

But is there any talk about consolidating these meal programs? And what's happening with the total amount of money? Are you asking for a reduction in money?

Mr. TORRES-GIL. In our fiscal year 1997 estimate, our overall request is 5 percent below our 1995 level. We're trying to do our part to share in terms of reductions, but to focus on the critical elements. What we have done is requested lesser amounts in the congregate meals program. But we've requested a slight increase in the home delivered meals programs.

What has happened over the years, Congressman, is that while our programs are extraordinarily popular, and we recognize that perhaps in serving the most vulnerable, those that are more likely to be living at home or disabled or frail, if we have to pick and choose, the home delivered meals programs were certainly perhaps the most critical. We have found that more states are shifting more of their dollars to home delivered meals programs. We now have approximately 48 percent of those dollars that go to home delivered.

We feel that if we have to pick and choose, we wanted to at least hold the line on the home delivered meals program. These recipients are people who, without a meal, could easily be in a nursing home. So it saves us money, it helps their self-esteem and preserves their independence. By integrating with other services, like senior companion or volunteers, we make a big difference with very little money.

We do allow states, however, to transfer a certain percentage of their dollars from congregate to home delivered. As I mentioned earlier, the trend seems to be toward putting more dollars into the home delivered program.

Mr. MILLER. It looks like a 10 percent reduction in home delivered meals.

Mr. TORRES-GIL. It may come down to that. I mean, I can't pick out the exact percentages there.

Mr. MILLER. It's \$105 million down to \$94 million.

Mr. TORRES-GIL. I might just add there, Mr. Chairman, when we put together this budget, the only figures we had to go on were some initial dollar figures that the House had proposed in 1995. And sometime back, the House had proposed approximately \$357 million for the congregate meals, as well as major reductions in other programs. So trying to be realistic with what seemed to be a very tough fiscal situation, we at least wanted to stay with what the House amount initially was.

Fortunately, in the fiscal year 1996 conference budget, the House did increase it to \$364 million. So we were certainly pleased that it went higher than what they had initially indicated. But again, given that there were tough choices, we would love to put more

money into that. But I felt that it was more important to invest in the home delivered meals programs.

Mr. MILLER. Well, I commend you for holding your budget steady as you have.

TRAINING RESEARCH AND DEMONSTRATION

On the research and demonstration projects, you have a large increase. How are you going to use it? You only have \$2.8 million this year?

Mr. TORRES-GIL. That's correct. First of all, I might add, our request in fiscal year 1997 for Title IV is, as you can see there, is close to \$12 million. That's about a 50 percent reduction from fiscal year 1995, which was about \$25 million. So that took the biggest hit, about a 50 percent reduction. Because our services are certainly first priority.

The fiscal year 1996 conference agreement is providing only approximately \$2.8 million. All of that is earmarked for either legal hotlines, Family Friends or the National Elder Care Locator. The reason that we felt we needed to ask for at least \$11.6 million is that these programs, as I mentioned earlier, are really the R&D, the heart and soul of the network's ability to become more efficient, to come up with the innovative demonstrations that allow us how to do more and how to deal with various trends.

As of this moment, Congressman, most of our Title IV grantees will be losing funding, and will be closing down with that \$2.8 million. My hope is to at least have 50 percent of what we had in fiscal year 1995. So we can fund programs, whether they're in domestic violence or for Native Americans, or our resource centers on nutrition, and grants to States for long term care, so that they can develop their own community development services.

In addition, disaster assistance has been provided to states through Title IV in the past. We provided quick response whenever there have been disasters like hurricanes in Florida.

So it's trying to find a balance between ensuring there are sufficient dollars and services, but making sure that we can continue to develop and innovate. I just might add, there is no other place in the Department of Health and Human Services that does this or is able to provide this, applied demonstration dollars that ultimately go to states and AAAs and local providers.

REAUTHORIZATION

Mr. MILLER. Let me switch back to the issue of the reauthorization again. Whether it's going to happen this year, and it seems like time may be running out, I haven't really talked specifically with the authorizers. Do you have a sense if they're going to have time to do it?

Mr. TORRES-GIL. I guess I'll ask Mr. Benson or Mr. Walker. They've been working very closely on this, they've been developing the bills and working with the staff on both sides.

Mr. MILLER. Then give me an idea of what your opinion is, I assume it's moving in the direction of more block granting, with more consolidation, but I don't know.

Mr. TORRES-GIL. If I can just respond first and let my colleagues also add their response. Our proposed reauthorization operated on

certain principles. One was certainly to provide more flexibility to states and local governments. Because they truly know how best to serve their populations. So we reduced various categories and sub-parts and allowed more discretion.

However, we feel strongly that we need to keep the Act intact, which means to keep critical parts of it, whether it's Title VII, the programs for vulnerable elders, Title IV, the R&D program, Title VI, the Native American program, certainly Title III, which are the nutrition and the supportive services.

We also want to ensure that we protect the vulnerable and continue targeting requirements for low income and minority elders, and that we continue to mandate certain services which we think without many states might not necessarily have the dollars for, and that would be programs like legal services.

We believe we've made great progress with both the House and the Senate in coming to a consensus in many areas. Mr. Goodling, for example, on the House side, certainly has worked with us to try to find a reasonable ground. Although we still have some disagreements on the House version. For example, they don't have the targeting provision, they have eliminated Title VII and the Ombudsman program as a separate program. They've eliminated Title IV, the R&D. So we're trying to find a way to deal with those differences.

On the Senate side, of course, we don't know yet what they're going to have. But let me ask Mr. Walker if he'd like to add anything.

Mr. WALKER. No, I don't have anything.

Mr. TORRES-GIL. Bill, on the timing?

Mr. BENSON. Mr. Miller, I think your assessment is probably most correct, that the clock is running out. And so our sense is that time is short, in order for them not only to be able to finish the work in each House, but then to reconcile the differences and put a bill together. So we would concur, the time is right now.

Mr. MILLER. I say that without talking with anyone on the committee. I just know what the calendar is like.

Are there any new programs you've got proposed?

Mr. TORRES-GIL. No, I don't think so. We are staying with the tried and true very successful programs. We will certainly have our hands full if the Congress approves the transfer of the other programs, as well as some internal transfers that we might be doing.

Again, this program, I might add, has been around for 30 years, and the Older Americans Act celebrated its 30th anniversary last year. We think it's just an excellent example of cooperation between the Federal government, states and local communities, and essentially basing everything from the bottom and working toward the top, essentially the pyramid, where we keep it small and nimble at the top and get as much down as we can at the bottom. Our overhead is just about 2 percent.

PRIORITIES FOR AGING PROGRAMS

So we're making the modifications to do things better. If you ask me what are our priorities in terms of directions, I would say community-based long term care. Increasingly, this aging network and state offices, like in Florida, are not only using our Older American

Act dollars to serve older persons, but they are able to leverage those dollars through Medicaid waivers, for example, to serve the elderly and the disabled. They are able to bring in state dollars. They get tremendous amounts of voluntary contributions.

Increasingly, this aging network is really an infrastructure that's serving other population groups that's able to bring in other sources of funding. I think it's being recognized as an excellent locus if states want to do things in terms of serving different populations.

One of our trends is to assist states, to expand community based long term care and social services, and to serve other populations that might have need of these types of programs.

Mr. MILLER. I used to serve on the board of directors of the Council on Aging a number of years ago.

Mr. TORRES-GIL. I should have you on this side, sir.

Mr. MILLER. This was 10 years ago or something, a while ago. But we had a day care program. It always seemed confusing sitting on a board. It seems there are so many different grants you have to go after. You'd have the main program, the day care, but then the meals were brought in by a congregate group, there were all these different programs, it always seemed so confusing with so many different programs.

It seems like it should be just one program. You don't need a separate one for meals and a separate one for teaching people how to work on taxes or do something else. And that was always, to me, the confusing part of it. I mean, I'm not sure how long you've been here, but it was certainly before my time here in Congress. I think it's gone through a couple of reauthorizations since then, and may be a lot better. But it's always struggling for money, it's always a problem.

Mr. TORRES-GIL. I might add, I've actually been in the field now for 20 years. I also served here on the Hill as staff director of the House Aging Committee about 10 years ago. So I've seen the evolution. One of our goals now is to try to move toward single points of entry, where a person that needs help doesn't have to go to a whole lot of different agencies, just one place, and they get all that they need.

I think we've made progress, perhaps, since the time you were on the Council on Aging. It's easier now. States have shown us the way, and now we at the Federal level are trying to catch up and make it easier for them to bring things together.

Mr. MILLER. We find this in so many areas. For example, in the job training area we're going through this in our community down there. It's just amazing, there are so many different areas and people involved in it. How do you put them all together. Florida is kind of a leader in developing the job training conference approach. So I'm glad they're getting ahead of the game because we haven't fully authorized it up here in that area.

I would ask my colleagues to ask a question, but we're not in session today, we finished up late yesterday, or early yesterday evening.

But thank you very much for being here today. I appreciate your testimony and comments. Thank you very much.

Mr. TORRES-GIL. Thank you.

Mr. MILLER. And we stand recessed until Tuesday at 10:00 a.m.

[The following questions were submitted to be answered for the record:]

OMBUDSMAN

Mr. Porter: With respect to the ombudsman program which is funded at a little over \$4 million a year, why shouldn't this be handled by the States? Why have a separate tiny categorical program for this at the Federal level?

Mr. Torres-Gil: Although most funding for ombudsman activities has traditionally and still does come from Federal Title III-B funding which State and area agencies on aging receive from a State's allotment and commit for this purpose, several factors led Congress, in FY 1992, to establish separate supplemental funding streams for both ombudsman and abuse prevention activities. These factors include:

- the need for additional resources for these activities, which address the needs of the most vulnerable and isolated elderly and which have been severely underfunded throughout the decades they have been in existence;
- the fact that, unlike other services under the Act which are provided by service providers who receive funds from the area agencies, both ombudsman and abuse prevention activities are provided directly by State and area agencies, as well as by service providers (in some instances); these are complex programs, which involve action and coordination at the State, regional and local levels to ensure effective statewide operations; therefore, it is necessary to have service dollars which can be clearly identified for these services;
- the need for clear identification of funds for these programs; without such identification, it would be easy for Title III-B services dollars to be used to supplement State and area agency administration dollars and be lost to program; this is why the Institute of Medicine, in their FY 1995 report on their study of the Ombudsman Program, recommended separate line funding for ombudsman activities; and
- the need to avoid distribution of these funds according to the Title III-B intrastate funding formula; if the monies were subsumed into Title III-B, complicated exceptions would have to be made to the usual way III-B funds are distributed; there were serious problems with this in FY 1991 and 1992, when small amounts of Title III funds had to be distributed to the AAA's according to the intrastate funding formula, thereby sacrificing statewide coordination of activities and providing such small amounts to each AAA that significant activities could not be accomplished.

Mr. Porter: Aren't the States simply paying for State staff with these Federal dollars?

Mr. Torres-Gil: The Title VII ombudsman funds are used for both State and regional/local program operations. They provide resources for staff; training; volunteer support; public awareness and education and other needs of State and regional/local ombudsman programs.

Mr. Porter: How much money is spent for ombudsman activities from all sources — State and Federal?

Mr. Torres-Gil: In FY 1994, Federal ombudsman funding from both Title III-B and Title VII (including abuse prevention funds, part of which some States use to supplement their ombudsman programs) was about \$25 million, which constituted 60% of the total FY 1994 funding of about \$42 million. State and local resources comprised the remaining 40%, which totaled about \$17 million. Figures for 1995, the latest year in which this data is available, are currently being compiled.

Ombudsman funding, which has grown over the years, is still much lower than it should be for effective statewide ombudsman services. The Institute of Medicine of the National Academy of Sciences determined that, for State ombudsman programs to carry out their current statutory mandate, one full-time ombudsman staff person should be provided for every 2000 long term care facility beds. (Distance and travel considerations would have to be calculated into this formula for States with more rural areas.) Using this formula, the IOM concluded that designated Federal ombudsman funding should be \$39.5 million by FY 1997.

Mr. Porter: What are the main purposes of the elder abuse prevention program?

Mr. Torres-Gil: The goals of State Programs for the Prevention of Elder Abuse, Neglect, and Exploitation are:

- to promote coordination of State and local programs and services engaged in identifying and assisting older individuals who are subject to abuse, neglect, and exploitation, including individuals living in private homes and State licensed and unlicensed facilities;
- to promote development of systems of coordinated prevention and treatment programs that include prompt investigation to substantiate the accuracy of reported instances of abuse; and, upon substantiation, to take steps to protect the health and welfare of the abused, neglected, and exploited older individual;
- to provide for training for individuals, professionals, and paraprofessionals on identification, prevention, and treatment;

- to provide for public education in how to recognize and report abuse, neglect and exploitation;
- to provide technical assistance to programs that provide or potentially may provide services for victims and for family members of victims; and
- to promote development of information and data systems, including elder abuse reporting systems, in order to quantify the extent of abuse, neglect, and exploitation; and to conduct analyses of the information.

Mr. Porter: What are the funds actually spent on in this program?

Mr. Torres-Gil: In Fiscal Year 1991 Congress first appropriated \$ 2.9 million to support the State Elder Abuse Prevention Program, authorized under Part G, Title III of the 1987 Older Americans Act. States were required to distribute the funds on a formula basis to the Area Agencies. Initially, the Area Agencies on Aging focused on public education and coordination with long-term care ombudsman programs.

The 1992 Amendments established a new Title VII and allowed States to elect to retain elder abuse prevention funds at the State level. Still many States continue to distribute the funds on a formula basis to the Area Agencies on Aging, as they were required to do under Title III.

Starting in Fiscal Year 1993 and up to the present, the States have expanded the amount of their expenditures to provide professional training and to promote coordination - increasing the number of separate categories of professionals and service providers from ombudsman to many others. In Fiscal Year 1995, awards ranged in size from the smallest award of \$23,409 to States such as Alaska, Nevada, and Delaware, to the largest award of \$448,777 to California.

States have used the funds to provide for in-service training. The categories of personnel trained have included aging services, adult protective services, ombudsman, health care aides, nursing home personnel, legal services, law enforcement, health care, hospital discharge planners, mental health, and postal and utility service workers. States have developed and conducted training teleconferences, and local, regional, and statewide training conferences. States have developed and distributed professional awareness brochures or training manuals and videos directed to specific professionals such as health care professionals, law enforcement officers, and guardians.

States have used the funds to support public education to educate individuals in how to recognize the symptoms of abuse and to know how and to whom to report it. States have supported the development and distribution of statewide public service announcements, videos, posters, brochures and pamphlets.

States have used the funds to promote coordination of multiple State programs and coordination of multidisciplinary local programs and services thorough support of an elder abuse staff specialist, creation of local and State Elder Abuse Committees to assess and prioritize elder abuse needs, problems, and recommend actions; development of interagency memoranda of understanding and protocols, and development of policy manuals. States have used the monies as seed monies to demonstrate new ideas at the local level and create a leverage to attract other State and local program dollars to continue the initiative on an ongoing basis.

States have used funds to support elder abuse hotlines for reporting suspected elder abuse.

Area Agencies on Aging have used the funds to support professional training workshops; and the purchase, development, and distribution of public service announcements, public and professional educational flyers, brochures, pamphlets, and posters.

Mr. Porter: How do you expect to successfully address this problem by spending a few million dollars on it at the Federal level?

Mr. Torres-Gil: There has not been an evaluation of the State Elder Abuse Prevention Program during its five years of operation. However, the limited Federal dollars serve a useful purpose in making available monies for education and training efforts to increase the preparedness of citizens and professionals to detect elder abuse early and prevent it from reoccurring. In addition there is a continuing need for in-service training of the workers who provide services for elder abuse victims and their families or services for older persons at risk for being abused. Most of these service provider categories are continually affected by the problems of worker turnover, stress and burn-out. Moreover, there is a need to provide in-service training for categories of service providers who have not been reached in previous State training efforts in order to increase the range of service providers who are able to detect elder abuse early and make referrals for appropriate follow-up interventions. For example, States are reaching out to law enforcement and the criminal justice system to educate them to the need for legal intervention and prosecution of criminal cases.

Mr. Porter: Another small program that you fund is the preventive health program. What are the main purposes of this small preventive health program?

Mr. Torres-Gil: Title III-F, Preventive Health Services, under the Older Americans Act, provides money to States which allows them the flexibility to meet the health promotion and disease prevention needs of seniors. A variety of 12 services are available, such as health screening and assessments; nutritional counseling and education; exercise programs; and, prevention of depression. These services take place at senior centers, nutrition sites, through home delivered meals programs or at other appropriate sites. According to the legislation, States are required to make grants according to State plans which give priority to areas of the State which are medically underserved and which are targeted to large numbers of older individuals who have the greatest economic need.

Mr. Porter: What impact has it had on the health and well-being of older people and is it measurable?

Mr. Torres-Gil: Health promotion and disease prevention activities can lead to preventable death and disability and enhanced quality of life. For example, increasing the level of exercise adds to a person's sense of well-being, ability to function and take better care of themselves in an independent setting. By emphasizing healthy lifestyle decisions, older people are maintaining optimum personal health.

Although we do not know of measures of the direct impact of these programs on individuals, Healthy People 2000 provides examples of measurement. One objective is to increase clinical breast examinations and mammograms. There has been an increase in the number of women aged 50 and over receiving such an examination from 25 percent in 1987 to 55 percent in 1993.

Mr. Porter: What is the rationale for maintaining this as a separate legislative authority, rather than folding it into the larger State grant under Title III?

Mr. Torres-Gil: Although title III-F is a small program and several of the activities may be provided under title III-B, it is important to focus attention on preventive health services, particularly because so many of the leading causes of chronic diseases are preventable and associated with lifestyle changes.

NUTRITION PROGRAMS

Mr. Porter: We note on page 26 of the justification that the home-delivered meals continue to increase as a percentage of the overall nutrition program. What is the explanation for this?

Mr. Torres-Gil: The number of home-delivered meals continues to increase as a percentage of the overall nutrition program due to an increased demand for home-delivered meals. This increased demand does not indicate a lessening of the need or demand for congregate meals. It means that the two programs are meeting the needs of two different populations and that there are increasing pressures to serve the home-delivered population.

The first reason is for the continuing increase is the changing demographics. There are more older people; more older people over the age of 85; more older people living alone; more older people in poor health living at home in the community; more older people who are functionally impaired living at home in the community; and more younger women, who are often primary caregivers, working outside the home so that they are not at home to provide all meals, etc..

The second reason for the continuing increase is change in the national health care system and the national home and community-based long term care system. There are more early discharges from hospitals under Medicare and as managed care in this population grows, this trend is expected to continue. Many people are discharged from the hospital before they are fully able to care for themselves, remaining unable to do ordinary daily tasks, but no longer in need of hospital medical care. There is an increase in home and community-based long term care options for older persons rather than premature institutionalization which increases the need for and demand for home-delivered meals.

The third reason for the continuing increase is change in the characteristics of home-delivered participants and is directly related to changes in both the health care and long term care system. Preliminary data from the National Evaluation of the Older Americans Act Nutrition Programs indicate that only 19% of home-delivered program recipients participated in the congregate program. There had been a belief that most home-delivered participants had aged in place and transitioned from the congregate to the home-delivered program as they became more frail. This belief holds true for 19% of the home-delivered participants; however, the rest of the participants, 81%, represent an entirely new pool of participants. Most of these participants have been referred for service by hospitals indicating an immediate acute health care need related to hospital discharge or an intermediate care facility indicating a more community-based long-term care need.

The fourth reason is that there is increased funding from federal as well as State and local resources for home-delivered meals. There have been increasing federal appropriations over the past 10 years for home-delivered meals; States have transferred increasing amounts from congregate to home-delivered meals; and there have been increased funds from other sources for home-delivered meals. Preliminary data from the National Evaluation of the Older Americans Act

Nutrition Programs indicate that State, local and private funds account for 17% of the cost of a congregate meal, but 33% of the cost of a home-delivered meal. Many nutrition projects report that it is easier to raise external funds for home-delivered meals because the need for them is often more apparent to potential donors.

Mr. Porter: How much money was transferred out the congregate meals program into the home-delivered program by the States in FY 1995?

Mr. Torres-Gil: In FY 1995, States transferred \$44,578,426 to the home-delivered program from the congregate program. This represented a 47.4% increase in the funds for home-delivered from \$94,065,000 to \$138,643,426. Congregate funds were decreased by 17.8 percent by transfers to home-delivered meals and supportive services.

Mr. Porter: Why wouldn't it make sense to simply consolidate the two programs and let the States decide how to split the money, rather than us doing it at the Federal level?

Mr. Torres-Gil: The Administration does not agree that it would be better to consolidate the congregate and home-delivered programs. Each program serves a different population and meets different needs of the older population along a continuum of long-term care services.

Most congregate participants fall at the end of the continuum that focuses on providing long-term preventive services. This population does have significant health problems, and many of these problems are nutrition-related and can be lessened by optimal food and nutrient intakes and other nutrition-related services. In addition, the preventive aspects of routine socialization, participation in exercise and disease prevention activities promote continued functionality. In addition, many congregate participants are nutritionally dependent on the congregate meal as their primary source of food for the day. Because the long term outcomes of these preventive activities may not be as readily apparent as the short term outcomes of a home-delivered meal, congregate programs may continue to lose funding as the immediate, acute need for home-delivered meals continues to grow.

Home-delivered participants have greater needs for long-term care services and the home-delivered meal is crucial to their ability to remain at home in the community. The immediate and acute care nature of this program is readily apparent and nutrition projects have found it easier to raise external funds to meet these needs.

Congregate programs have expressed a concern that States might significantly limit or eliminate the congregate program, even when there is demonstrated need, in order to meet the increasing demands for home-delivered meals that are occurring as a result of changes in the health care and long term care systems.

The current law provides States with considerable flexibility to transfer funds and does not appear to be an impediment to States dividing the funds between the congregate and home-delivered programs. Preliminary data from the National Evaluation of the Older Americans Act Nutrition Programs indicate that States transferred about 17 percent of the funds initially allocated to the congregate program to other uses in the 10 years examined. About two-thirds of the transferred funds went toward home-delivered meals.

Although the law allows States to request a waiver to increase the amount transferred from one allocation to another, no State in the 10 years examined asked for a waiver to increase the amount transferred to either supportive services or to home-delivered meals, indicating that the current limitations do not appear to be an impediment to being responsive to State needs.

The congregate program is also more dependent on federal funding than is the home-delivered program. Preliminary data from the National Evaluation of the Older Americans Act Nutrition Programs indicate federal funding accounts for 48% of the cost of a congregate meal, but only 34% of the cost of a home-delivered meal.

The Administration believes that the provisions of the current law which provides some protection for the congregate program are working well and that the current law allows States flexibility to transfer funds and to request a waiver to increase the amount transferred if a State desires.

Mr. Porter: The Administration proposes to transfer the U.S. Department of Agriculture nutrition program to the Administration on Aging in FY 1997. What are the benefits of transferring administrative authority to your agency? What impact would this have on the operation of the program?

Mr. Torres-Gil: As part of the National Performance Review (NPR) and in response to a study by the General Accounting Office, the Administration proposed this transfer to produce the following benefits. As part of the NPR, the AoA proposes to consolidate a number of aging programs to improve and facilitate access by older consumers. In addition, the consolidation of the two nutrition programs is designed to achieve administrative efficiencies. Currently the two programs are administered by two separate federal agencies requiring two separate applications, reporting systems, and monitoring processes of States, tribes, area agencies on aging, and local providers. Consolidation would decrease the administrative and paperwork burden on these entities.

Not only would reduced paperwork positively impact the program operations, but the consolidation would improve State, tribal, and local planning and administrative processes through a different method of fund distribution. The new fund distribution method that would eliminate retroactive per-meal reimbursement rate decreases or increases, provide a single rate for the entire year and may decrease the number of times a State or tribe needs to report to the federal government.

Mr. Porter: Would the funding for the program be retained in the Agriculture budget for now?

Mr. Torres-Gil: The Administration proposes that the funding for the program be retained in the Department of Agriculture's appropriations committee.

SOCIAL SERVICES BLOCK GRANT

Mr. Porter: As we understand it, Social Services Block Grant (SSBG) funds can be used by the States to fund a variety of activities related to Older Americans. Are we correct in this understanding?

Mr. Torres-Gil: The SSBG may be used at State discretion to fund a number of services related to older Americans. The home and community based services most often provided to the elderly from SSBG are Personal Care, Homemaker/Chore, Home Delivered Meals, Adult Day Care/Health, Home Health Aide, Transportation, and Respite Care.

Mr. Porter: Do you know to what extent States are using these funds to serve the elderly? What kind of reports do you get?

Mr. Torres-Gil: We conducted a special survey of our State Units on Aging in 1993 on Home and Community Based Services to the elderly provided from various sources, including non-Older Americans Act funds, such as the SSBG. We are not aware of any other specific information on how States use the SSBG. Nationally, SSBG provided \$647,000,000 in 1992 for home and community-based care for the elderly. This represents 10.1 percent of the total funds spent on home and community-based care for the elderly in 1992 in the United States. In eleven States the State units on aging administered SSBG funds in support of home and community based services.

Mr. Porter: What attempt is made to coordinate programs under the Older Americans Act with activities under the SSBG?

Mr. Torres-Gil: Coordination of Older Americans Act programs with activities under the SSBG can only occur at the State level, since SSBG is administered almost entirely at the discretion of the States. State Units on Aging work within State government to increase the resources (including SSBG) available to serve the functionally impaired elderly.

RESEARCH AND DEMONSTRATION

Mr. Porter: You're requesting \$11.6 million in 1997 for discretionary activities under title IV of the Act. This is an increase of nearly \$9 million over the recently enacted appropriation for 1996. Why is this increase justified?

Mr. Mr. Torres Gil: I should point out that the 1996 appropriation of \$2.85 million represents a very severe cut in the Title IV program of almost 90 per cent from the FY 1995 funding level, which was \$25.5+ million. Thus, the Administration request for \$11.6 million seeks to restore the Title IV program to a much more reasonable level, a funding level which clearly recognizes fiscal constraints but is still adequate to meet several high national priorities in determining better ways of serving older Americans.

Mr. Porter: How exactly would you plan to spend these funds if you got them?

Mr. Torres-Gil: I want to reemphasize that the proposed funding level of \$11.6 million is tempered by an understanding of contemporary budget realities as well as the greater priority on providing services to the elderly under Older Americans Act programs. On the other hand, it also reflects our rock-bottom assessment of the investment necessary for this vital discretionary program to prepare the nation for a doubling of the older population. Title IV remains critical to determining how best to serve older persons and their families, now and in the 21st century, through applied research, innovative model programs, better trained personnel, and timely technical assistance and information.

The following priorities will guide the allocation of FY 1997 Title IV funds:

- 1) Meeting congressional mandates for such programs as senior legal hotline model projects, family friends demonstrations, and the national eldercare locator;
- 2) Expanding the current system of consumer directed home and community-based long-term care for older persons and others with disabilities, with a special emphasis on Alzheimer's Disease victims and their caregivers;
- 3) Developing a blueprint for the retirement of the baby-boom generation;
- 4) Protecting older persons from crime, violence, abuse, and exploitation; and
- 5) Advancing our understanding of how to better serve minority elderly.

Mr. Porter: On page 32 you talk about using these funds "to develop a blueprint for the retirement of the baby-boom generation". How would your agency develop such a "blueprint"?

Mr. Torres-Gil: As we begin to motivate baby boomers to make thoughtful choices for the future, we recognize that it will require the talents and commitment of all levels of government, business, labor, a wide range of groups and organizations, and most importantly it will require individuals to take personal responsibility for ensuring they enjoy a good quality life in their later years.

AoA is working as the catalyst to advance public and private sector partnerships, encourage policy dialogue at the national, State and local levels, and promote public awareness and education.

One part of this effort included convening a national invitational meeting in Washington, D.C. on May 13th. This meeting brought together a cross-section of individuals from the public and private sectors to discuss major challenges and develop draft objectives in the areas of individual financial security, health, and quality of life. The unique role of AoA is to approach the issue of planning from a comprehensive perspective which includes health and quality of life issues, as well as financial well-being. Follow-up activities will include:

- Workgroups scheduled to meet during June, July and August to further refine and define the planning objectives; and
- Opportunity for extensive discussion and review through regional meetings scheduled to begin in the fall of 1996.

Through a Memorandum of Understanding (MOU), the Social Security Administration and AoA will engage in collaborative activities to promote the well-being of older persons by providing a coordinated, integrated response to the needs, problems, and concerns of older persons. A major focus of the agreement is to foster social change by educating middle-aged and younger groups about planning for a longer life span and for their retirement security in a society that is experiencing demographic shifts.

The Department of Labor (DOL) launched a retirement savings education campaign in July 1995 in a effort to raise public awareness about pensions and the need to save enough money for retirement. The focus of the campaign is to encourage participation in employer pension plans and other savings vehicles. AoA is working with DOL to promote this endeavor and will be exploring other collaborative efforts.

DISCRETIONARY ACTIVITIES

Mr. Porter: You received \$2.85 million for discretionary activities in the FY 1996 appropriation. How do you plan to spend those funds?

Mr. Torres-Gil: The FY 1996 appropriation of \$2.85 million will be allocated according to the applicable provisions of Senate Report 104-145 accompanying H.R. 2127, namely:

- a) \$1,500,000 million for senior legal hotlines and related elder rights projects mandated by the Older Americans Act;

- b) \$600,000 to continue the Family Friends/Volunteer Senior Aides program; and
- c) \$750,000 to provide level funding for the eldercare locator.

Mr. Porter: Why wouldn't it make sense to have the Assistant Secretary for Planning and Evaluation carry out these kinds of activities, instead of having two different agencies involved?

Mr. Torres-Gil: --If the Title IV program was devoted to evaluative research, one could make a case for transferring the program under the umbrella of the Office of the Assistant Secretary for Planning and Evaluation (ASPE). But, the Title IV program is only in part, a small part, a research program and the emphasis is on applied, not evaluative research. Since 1965, the Older Americans Act has always mandated a multi-dimensional discretionary grant program, which went well beyond research to emphasize--

- demonstration and model projects for testing innovative and better ways to serve older people;
- education and training projects to ensure that knowledgeable and skilled persons plan and deliver those services;
- information dissemination, technical assistance, and related capacity-building resources to equip the aging network with an understanding of our older population and with added know-how of what works, of what the best practices are, to get their job done well in 50 States and thousands of communities.

Through Title IV, the Administration on Aging (AoA) has had the resources to develop prototypes for nutrition programs, home health services, legal services, transportation, respite care, adult day care, reverse mortgages, and many other innovative services. The purpose of Title IV is essentially to determine how effectively new programs and services would promote and protect the independence, rights, and dignity of older Americans in their communities.

The proposals pending in the House and the Senate to reauthorize the Older Americans Act unmistakably endorse this kind of multi-faceted, results-oriented, highly practical, program of discretionary projects and activities. I believe that it is because the Congress recognizes the real worth of continuing the Title IV program and understands that while ASPE may have many talents, carrying out the type of program I have just described is not one of them.

ADMINISTRATIVE COSTS

Mr. Porter: You're hoping to get an increase of \$1.6 million for your administrative costs in 1997, an increase of over 10 percent from the recently enacted 1996 amount. Why is it necessary to have an increase of this magnitude in your overhead costs?

Mr. Torres-Gil: The additional amount requested for the Federal Administration activity is needed to support the full funding of 177 full-time equivalent positions including funds to cover built-in increases such as annualization of the FY 1996 pay raise, 3% pay increase for three quarters of FY 1997, hardware and software upgrades to support the Information Resource Management efforts for AoA's "Rightsizing" initiative and modest amounts for increasing costs of rent, postage and other administrative costs.

Mr. Porter: How many FTE's will you support in FY 1996, and how does that compare with FY 1995?

Mr. Torres-Gil: The current funding amount would support 161 FTE positions which is 16 fewer than the 177 FTE authorized level for FY 1995 and for FY 1996.

Mr. Porter: Would the number of FTE's increase in 1997 under your budget proposal?

Mr. Torres-Gil: The FTE level would remain at 177, the same authorized for FY 1995 and FY 1996.

Mr. Porter: Why do you think that we need a Federal Council on Aging? As you know, Congress did not fund the Council in the 1996 appropriations bill.

Mr. Torres-Gil: The Federal Council on the Aging (FCoA) is the only citizen advisory agency within the executive branch charged with advising and assisting the President on the special needs and characteristics of older Americans in the local communities. Without the council, there is a missing link between and across government agencies and the voice of the older American in the local communities. Mandates of the FCoA include advising the President on matters related to the special characteristics of older persons, serving as spokespersons on behalf of older Americans and their families by making recommendations about Federal policies and programs, and issuing annual and interim reports to the President on key findings and priority recommendations.

STATE OF THE ELDERLY

Mr. Stokes: What is the mission of the Administration on Aging?

Mr. Torres-Gil: The Administration on Aging was established by the Older Americans Act (OAA) of 1965 to serve as the leading advocate within the Federal government for older Americans. In that capacity, AoA has for over 31 years provided leadership, oversight, technical support and partnership (as well as funding) to 57 State Units on Aging, 670 area agencies on aging and over 221 tribal grantees serving more than 300 tribes. AoA's OAA programs provide protection, support, nutrition, and other critical services that allow older persons to remain living independently within their homes and their communities. The Administration on Aging also works closely with 27,000 service providers including 6,000 senior centers throughout the country to serve seniors and their families. AoA is unique in the fact that it is truly a grass-roots community-based program. Advisory Councils composed mostly of seniors, local leaders and consumers provide valuable guidance in the development of plans to address the unique needs of the elderly. Their responsibility is to assure access to services for seniors and their caregivers. This collaboration is critically linked on a national level through the Administration on Aging's Eldercare Locator program.

AoA also has provided funding for hundreds of research and demonstration projects across the country, which have been the catalysts behind successful local and community programs such as "meals on wheels" and the ombudsman program. The Administration on Aging also has provided disaster relief funds for older victims of Presidentially-declared disasters across the country.

Mr. Stokes: In your professional judgement, what is your assessment of the State of the nation's elderly?

Mr. Torres-Gil: The State of the nation's elderly can best be described as diverse. According to the most recent Census Bureau information, the majority of today's elderly are healthier and more well off financially than in the past. This is largely because of the existence of various Federal programs such as Social Security, Medicare and Medicaid and the Older Americans Act which were created over the last 30 to 60 years to make life more comfortable for Americans in their mature years, and because of pension protections. However, many older Americans, in particular the minority elderly, can be classified as poor or "near poor." About one fourth of all elderly blacks and Hispanics are poor, and more than half of elderly black women who live alone are poor. In addition, the number of elderly over the age of 75 is growing and with that growth, we will see a greater need to provide critical services to a large and more frail population.

It is important to acknowledge that as baby boomers grow older and the number of retirees significantly increases, the strain on federal programs will be much greater. By the year 2030, it is estimated that the number of people aged 60 and older will increase to 89 million, representing 25% of the total population, while those 85 and older will increase to almost 9 million. Minority populations

are projected to represent 25% of the elderly population in 2030, up from 13% in 1990. These demographic trends will also call for an increased demand for - and will place a tremendous burden on - caregivers -- providing yet another challenge which our nation will have to address.

Mr. Stokes: What impact would the health care proposals currently under consideration in the Congress have on seniors?

Mr. Torres-Gil: The Department is in the process of assessing the impact on seniors of health care proposals recently introduced in Congress. We will be happy to share this analysis with the Committee as soon as it is completed.

MEALS FOR THE ELDERLY

Mr. Stokes: How many meals for the elderly will the FY 1997 budget request allow you to provide and how does this compare with the number provided by final action on the FY 1996 appropriations bill?

Mr. Torres-Gil: The final FY 1996 appropriations bill has provided more funding for congregate and home-delivered meals than is in the FY 1997 budget request. The Administration anticipates that the FY 1996 appropriations will allow 123,058,937 congregate meals to be provided and 127,193,057 home-delivered meals to be provided. The Administration anticipates that the FY 1997 budget request will allow 120,597,758 congregate meals (a 2 percent decrease from FY 1996) and 113,201,821 (an 11 percent decrease from FY 1996) home-delivered meals to be provided.

Mr. Stokes: To what extent are the seniors dependent upon these meals?

Mr. Torres-Gil: For many seniors, these meals are their primary daily food source. Preliminary data from the National Evaluation of the Older Americans Act Nutrition Programs indicate that individuals receiving meals have higher daily intakes of key nutrients than similar nonparticipants. In addition, the meals provide approximately 40 to 50 percent of participants' daily intake of most nutrients. Over one-third of home-delivered participants eat part of the program meal as a second meal, part of a second meal, or as a snack. Twelve percent of congregate participants take either a full meal or snack home from the site for later consumption. Nearly all home-delivered participants and one-half congregate participants receive five or more program meals a week.

Many seniors participating in Older Americans Act nutrition programs have functional impairments that decrease their ability to obtain and prepare food. They are dependent on these meals for that food. Preliminary data from the National Evaluation of the Older Americans Nutrition Programs indicate that 12.8 percent of congregate and 63.9 percent of home-delivered participants cannot grocery shop compared to 11.5 percent of all Medicare beneficiaries. Also, preliminary data from the National Evaluation of the Older Americans Nutrition

Programs that indicate that 7.5 percent of congregate and 41.3 percent of home-delivered participants cannot prepare their own meals compared to 6.6 percent of all Medicare beneficiaries.

Many seniors participating in Older Americans Act nutrition programs are classified as either poor or near poor and are therefore dependent on the program as a basic food assistance program. Preliminary data from the National Evaluation of the Older Americans Nutrition Programs indicate that about one-third of congregate and one-half of home-delivered participants have incomes at or below the DHHS poverty line; between 80 and 90 percent have incomes below 200% of the DHHS poverty line. This data also indicates that despite participation in the nutrition program, 10 percent of congregate and 16 percent of home-delivered participants experienced food insecurity in the past month.

Mr. Stokes: Describe the profile of the average senior who has to depend on these meals.

Mr. Torres-Gil: The average congregate and home-delivered participants are different from each other on various dimensions so that I will describe first an average congregate participant and then an average home-delivered participant. These descriptions are based on preliminary data from the National Evaluation of Older Americans Act Nutrition Programs.

The average congregate participant is 76 years old, female, and lives alone. Thirty-four percent of congregate participants are below 100 percent of the DHHS poverty line and 79 percent are below 200 percent of the DHHS poverty line. Forty-one percent have three or more chronic health conditions; 25 percent have been hospitalized in the past year; and 61 percent have a body mass index (an indicator of over or under weight) that places them at nutritional risk. In regard to functional capacity, 12.8 percent are unable to grocery shop and 7.5 percent are unable to prepare a meal. Ninety-one percent are able to get out of the house at least once per week.

The average home-delivered participant is 78 years old, female, and lives alone. Forty-eight percent of home-delivered participants are below 100 percent of the DHHS poverty line and 90 percent are below 200 percent of the DHHS poverty line. In regards to health, 59 percent have 3 or more chronic health conditions; 43 percent have been hospitalized in the past year; and 64 percent have a body mass index (an indicator of over or under weight) that places them at nutritional risk. In regards to functional capacity, 63.9 percent are unable to grocery shop and 41.3 percent are unable to prepare a meal. Forty-six percent are able to get out of the house at least once per week.

INCREASING NUMBER OF SENIORS

Mr. Stokes: According to the justification, by year 2030, the number of people aged 60 and over will increase to 89 million, while those 85 and older will increase to almost 9 million. To what extent is the agency positioning itself to respond to this increasing need for services?

Mr. Torres-Gil: Meeting the needs of this future generation of Older Americans requires the talents and commitment of all levels of government, business, labor, a wide range of national and local groups and organizations. Most importantly, it requires the Administration on Aging (AoA) to take the lead in encouraging and supporting individual responsibility to ensure that these individuals enjoy a quality life in their later years.

The Administration on Aging is positioning itself to approach the issues by involving and bringing together a cross-section of individuals from the public and private sectors to discuss the obvious individual needs for financial security, health, and quality of life. AoA's role is to continue its unique approach of planning, educating and providing technical assistance from a comprehensive perspective. AoA has spent the past thirty one years assisting State and local communities to develop comprehensive and coordinated service delivery systems. We believe this approach will continue to be effective in identifying and assisting future older individuals to adopt the self-preparation and positive planning behaviors critical to successful behavior in order to achieve fulfilling lives.

WORK OPPORTUNITIES

Mr. Stokes: What provisions and how much funding is included in the FY 1997 budget request to address work opportunities for the nation's seniors who need and want to work?

Mr. Torres-Gil: Under Title V of the Older Americans Act, the current statute requires the Department of Labor (DOL) to award grants for the Senior Community Service Employment Program (SCSEP) to all States, the District of Columbia, Puerto Rico and the territories and to 10 national nonprofit sponsors to train unemployed low-income older Americans 55 years and older and help them to find part-time employment in useful community service activities, that often serve as bridges into permanent employment.

Over the past three decades, this very successful program has served from 67,000 to 100,000 older persons each year, of whom about 70 percent are women enrollees, 56 percent are over the age of 65 and about 40 percent are members of a minority group.

Currently, there is under consideration reauthorizing legislation (provisions in S.1643 and H.R. 2570) for the Older Americans Act that addresses transferring the administration of the SCSEP from DOL to the Administration on Aging (AoA) with a proposed budget of \$350,000,000.

MEDICARE AND MEDICAID

Mr. Stokes: The Administration proposes to cut outlays for Medicare and Medicaid by \$124 billion and \$59 billion respectively. In your professional judgement, what will be the impact of each of these proposals on the nation's seniors?

Mr. Torres-Gil: In order to address the Federal budget deficit, we have had to make difficult choices. We believe these proposals have been crafted to protect beneficiaries and give seniors more choice among private health plans.

In order to help control costs and avoid unnecessary institutionalization, I believe we will need to strengthen our community support programs for families, such as those provided through the Older Americans Act. These programs assist older persons to live with dignity in their homes and familiar neighborhoods, often at lower expense to the taxpayer.

They also provide some help and relief to family caregivers. More than 80% of the caregiving provided in the United States is from family members. While these families are not looking for the government to intrude on their responsibilities, they are increasingly looking for the types of case management, caregiving relief, and community-based supports which can help them better help themselves.

The fact that people are living longer will also provide added pressure on the Older Americans Act's senior nutrition programs in terms of providing preventive care and to assist frail and vulnerable persons when they are released from hospitals and nursing homes.

Mr. Stokes: Describe the profile of the seniors who would win, and of those who would lose.

Mr. Torres-Gil: Seniors, disabled persons, and families who would win are middle- and low-income persons who rely on Medicaid as a safety net. Medicaid pays for slightly more than half of all nursing home care for the elderly and disabled because the annual cost of nursing homes (now averaging \$38,000 per year) is too high for most American families to pay on their own. The Administration's Medicaid proposals would maintain and protect this vital function.

All seniors would win under the Administration's Medicare proposals because they are focused on controlling costs, attacking waste fraud and abuse, and strengthening the trust funds for an additional ten years without imposing any new out-of pocket costs.

SENIORS' CONCERNS

Mr. Stokes: For the record, what are the five major concerns of the nation's seniors, and to what extent can and does the FY 1997 budget address them?

Mr. Torres-Gil: There are no definitive survey data which provide a consistent measuring rod of the concerns of the nation's elderly, but certainly the following would be high up on any current list:

- a standard of income that would provide for life's necessities over an ever increasing period of longevity
- reasonably good health that would enable one to continue to an active, productive, and contributing member of society
- a sense that one's home, one's property, and most importantly, one's person is safe and secure
- having the opportunities to pay back in principal and interest to your family, your community, and your country all that they have invested in you over many, many years
- a concern that this nation will continue to honor justice and extend the blessings of liberty to our children and grandchildren, and to newcomers to this land.

The FY 1997 budget for AoA, consistent with the mandates and priorities of the Older Americans Act, focuses on maintaining the independence, dignity, and resourcefulness of older Americans. The funding matches the emphasis in our legislation on home and community based care, on sound nutrition, on services to support self-reliance and productivity, and on safeguarding the rights and persons of our older population. Thus, the funding of Older Americans Act programs plays a key part in sustaining what is best in our elderly and best for the nation as well.

Mr. Stokes: What are the five major fears of the nation's seniors, and to what extent can and does the FY 1997 budget address them?

Mr. Torres-Gil: As with the concerns face by seniors, it is difficult to say any particular set of fears have primacy, but the following are certainly worth noting:

- the generalized, all-embracing fear of losing one's independence
- the fear of spending one's last years in a nursing home or other institutional setting

- the fear of falling victim to Alzheimer's disease or other dementia, or other terminal disease, the result of which is one becomes, for a protracted period, a burden on loved ones
- the fear of losing one's self-sufficiency, of becoming dependent upon one's children, or other relatives, or public assistance programs
- the fear of crime, especially violent crime, but also exploitation

The funding of Older Americans Act programs in FY 1997 speaks more to answering the concerns of older persons and less to answering their fears, such as the fear of a terminal illness. Nonetheless, our focus on home and community based care, on sound nutrition, on services to support self-reliance and productivity, and on safeguarding the rights and persons of our older population responds directly to some of the fears just mentioned.

DEMOGRAPHICS OF ELDERLY

Mr. Hoyer: I am concerned that, as our population ages and as programs which are important to our seniors are reduced, the net effect is to substantially reduce aid to elderly individuals at a time when our elderly population is growing. Could you describe the changing demographics of our elderly population? Are our seniors better able to take care of themselves, and therefore less reliant on your programs? The AoA budget request for 1997 is \$828 million, nearly \$50 million below the 1995 budget. Does this reflect a reduced need for AoA programs?

Mr. Torres-Gil: The transition of baby boomers into the ranks of old age will not simply be a matter of greater numbers and higher proportions of older Americans living within the policies, institutions, and economic and social contexts of today. It's not just their sheer numbers that promise to redefine what it means to grow old in America. As the best-educated, most affluent and healthiest generation in the nation's history, boomers are poised to rewrite the story of aging in America.

It would be a mistake, however, to characterize a group as colorful and diverse as the baby boomers as a monolith. According to a recent study conducted for AARP, a permanent economic underclass of baby boomers appears to be emerging -- disproportionately represented by African Americans, single women and those poorly educated. By 2030, minorities will account for more than one quarter of the older population, up from 13 percent in 1990.

Individuals are living longer, but non-fatal diseases and disabilities of old age are likely to present a formidable challenge. In 1987 the 65+ group represented 12% of the U.S. population but accounted for 36% of total health care expenditures. We do not anticipate that reality to change.

Older Americans Act (OAA) programs currently serve a small percentage of the elderly population. With the anticipated demographic changes, significant numbers of individuals will still need these programs. The budget request reflects the reality that has faced us throughout this decade - we must continue to provide services with fewer resources. OAA programs have always leveraged other funds and we expect that they will continue to do so.

FUNDING JUSTIFICATION

Mr. Hoyer: As I look at the budget request for 1997, I see very small or no increases in important programs such as Congregate Meals, Home-Delivered Meals, In-Home Services, and Preventive Health Services. However, the request for the Federal Council on the Aging is a 50% increase from 1995, and federal administration costs are nearly \$1 million higher than 1995 even though your FTE figures have not changed. How do you justify holding services essentially flat to pay for these other increases?

Mr. Torres-Gil: The members of the Federal Council on the Aging are selected by the Congress and the President to be the President's citizen's advisory committee on important issues related to nutrition, in-home services, preventive health, elder abuse, mental health and aging, community-based long-term care, and a host of other matters related to the Act. As such, an appropriation of \$233,000 to help provide the President with the local community views of nearly 33 million people and their families is a minimum investment in helping to assure quality and accountability.

At a minimum, the Council is statutorily mandated to hold quarterly meetings and to print and disseminate an annual report. The FY 1995 budget is too small to meet even this minimum mandate to meet four times per year and to print its annual report.

In addition, under the Presidentially-appointed Chairman, the Council has developed consumer-oriented materials on mental health, home- and community-based long-term care, and elder abuse prevention.

The Council has also been directed to work to follow-up on the recommendations passed by the delegates to the 1995 White House Conference on Aging.

NUTRITION PROGRAM FUNDING

Mr. Hoyer: Last year, I visited a Congregate Meals site in the Fifth District of Maryland. I was impressed by the comraderie of the seniors who participate in meal service there, and by the contributions made by the program and the staff to keeping seniors active, cheerful and healthy. I understand that the seniors contribute, on a voluntary basis, as much as they can afford to keep this program running. How much money is raised through this voluntary contribution approach?

Mr. Torres-Gil: For FY 1994, the year in which we have the most current data, 173 million dollars were contributed by seniors to the nutrition program. Given that most of the seniors would be considered poor or near poor, the amount of voluntary contributions shows both personal responsibility and ownership of the program that seniors have. Preliminary data from the National Evaluation of the Older Americans Nutrition Programs indicate that about 20 percent of the cost of a meal is paid by seniors through monetary contribution. In addition, voluntary labor contributes about 9 percent of the cost of the meal. Thirty-five percent of congregate participants volunteer their time to perform program tasks such as setting up meal sites, collecting contributions, and delivering meals.

Mr. Hoyer: How much State and local funding does the federal contribution leverage?

Mr. Torres-Gil: Preliminary data from the National Evaluation of the Older Americans Act Nutrition Programs indicate that State, local, and private funds account for approximately 17 percent of the cost of a congregate meal and 33 percent of the cost of a home-delivered meal. For every \$1.00 in Title III funds for congregate, \$2.70 in total resources is devoted to the program. The leveraging rate for home-delivered is somewhat higher. The average federal contribution to the congregate program is considerably higher than the federal contribution to the home-delivered program.

Mr. Hoyer: How many seniors could we serve if we had to rely solely on the federal funds provided?

Mr. Torres-Gil: Preliminary data from the National Evaluation of the Older Americans Act Nutrition Programs indicate that federal funds contribute 48 percent of the cost of a congregate meal and 34 percent of the cost of a home-delivered meal. Administration on Aging 1994 participation data indicate that 2,292,742 individuals participated in the congregate program and 877,344 participated in the home-delivered program. The Administration believes that the ability to serve eligible, needy participants would be proportionally reduced if the program were solely dependent on federal funds.

Mr. Hoyer: How many additional seniors can we help with the private, local and State funds contributed?

Mr. Torres-Gil: Preliminary data from the National Evaluation of the Older Americans Act Nutrition Programs indicate that 50 percent of the cost of a congregate meal and 66 percent of the cost of a home-delivered meal is from participant contribution, local in-kind donations, volunteer time, State, local, and private funds. These programs have only been able to expand service to the ever increasing pool of needy seniors through fund raising efforts in both the private and public sector. The Administration believes that the ability to serve this population is proportionally increased by the network's ability to access other funding.

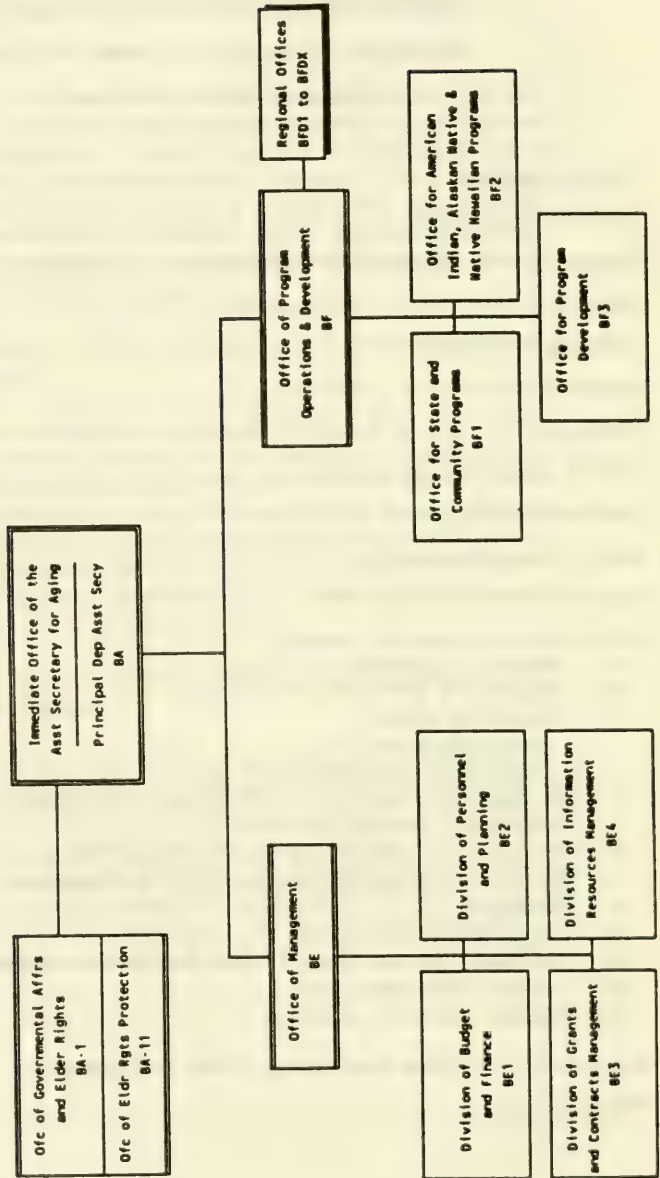
JUSTIFICATION OF THE BUDGET ESTIMATES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration on Aging

<u>FY 1997 Budget</u>	<u>Page</u>
Organization chart.....	1
Appropriation language and explanation of language changes..	2
Amounts available for obligation.....	3
Summary of changes.....	5
Budget authority by activity.....	6
Pie chart.....	7
Budget authority by object.....	8
Administrative costs.....	9
Authorizing legislation.....	10
Appropriation history table.....	13
Justification/Account Summary.....	14
A. General Statement.....	15
B. Supportive Services and Centers.....	16
C. Nutrition Meals:	
Congregate Meals.....	18
Home-Delivered Meals.....	22
D. In-Home Services for Frail Older Individuals.....	27
E. Preventive Health Services.....	29
F. Training, Research and Discretionary Programs.....	31
G. Grants to Indian Tribes and Native Hawaiians.....	33
H. Ombudsman.....	35
I. Elder Abuse Prevention.....	38
J. Outreach, Public Benefit and Insurance Counseling.....	40
K. Federal Administration.....	41
M. Federal Council on Aging.....	42
Detail of Full-Time Equivalent (FTE) Employment.....	44
State tables.....	45

Administration on Aging
Reorganization 9/30/95



Department of Health and Human Services

Administration on Aging

For carrying out, to the extent not otherwise provided, the Older Americans Act of 1965, as amended, and section 10404 of Public Law 101-239 (volunteer senior aides demonstration), \$828,137,000. (*Department of Health and Human Services Appropriation Act, 1995*).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING
Aging Services Programs

Amounts Available for Obligation

	1995 Approp- riation	1996 Policy 1/	1997 Estimate
Appropriation:			
Annual.....	\$876,236,000	\$828,000,000	\$828,137,000
Enacted rescission...	229,000	0	0
Subtotal, adjusted appropriation.....	876,007,000	828,000,000	828,137,000
Subtotal, adjusted budget authority..	876,007,000	828,000,000	828,137,000
Offsetting collections from:			
Federal funds.....	803,589	0	0
Unobligated balance available, start of year.....	0	0	0
Unobligated balance available, end of year.....	0	0	0
Unobligated balance, lapsing.....	478,529	0	0
Total obligations.....	\$876,332,060	\$828,000,000	\$828,137,000

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING
Aging Services Programs

Amounts Available for Obligation

	1995 <u>Approp-</u> <u>riation</u>	1996 <u>Policy</u>	1997 <u>Estimate</u>
<u>Proposed Legislation:</u>			
Transfer from Department of Agriculture.....	\$150,000,000	\$150,000,000	\$150,000,000
Transfer from Department of Labor.....	396,000,000	350,000,000	350,000,000
Total proposed transfers.....	\$546,000,000	\$500,000,000	\$500,000,000

SUMMARY OF CHANGES

1996 Policy/appropriation.....	\$828,000,000
1996 Proposed supplemental.....	-0-
 Total estimated budget authority..... (Obligations).....	 828,000,000
 1997 Estimate..... (Obligations).....	 828,137,000
 Net change..... (Obligations).....	 +\$137,000

	1996 Current		Change from Base	
	Estimate Base	Budget		Budget
	(FTE)	Authority	(FTE)	Authority
Increases:				
<u>A. Built-in:</u>				
1. Provide for January, 1997 3% pay raise and related costs.....	177	10,834,000	0	+168,330
2. One extra day of pay.....		10,834,000		+41,670
3. Increased costs associated with Federal Health Benefits and FERS.		1,634,000		+128,000
4. Increased costs related to rental of space, postage and telecommunications.....		1,700,000		+50,000
5. Increased costs related to printing and reproduction, supplies, equipment, travel and transportation of things....		433,000		+13,000
6. Hardware upgrades consistent with IRM rightsizing initiatives.....		545,000		+88,000
Total increases.....			-0-	\$489,000
Decreases:				
<u>B. Program:</u>				
1. Research, Training and Demonstration.....		12,018,000		-352,000
Total decreases.....			-0-	(\$352,000)
Net Change.....			-0-	+\$137,000

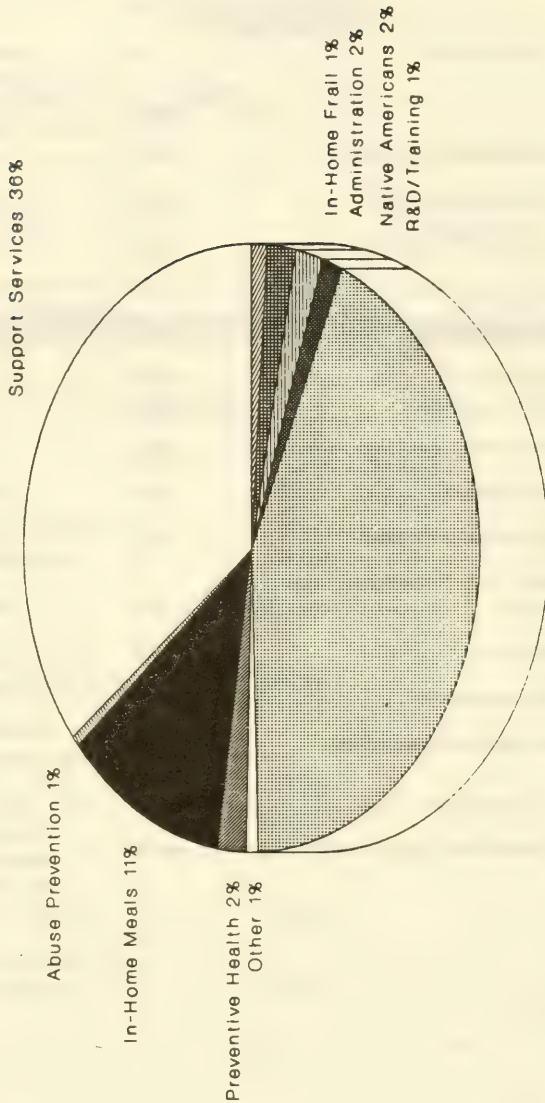
Budget Authority by Activity
(dollars in thousands)

	<u>1995 Actual</u>		<u>1996 Policy 1/</u>		<u>1997 Estimate</u>	
	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>
1. Supportive Services and Centers.....		306,711		294,787		294,787
2. Aging Congregate Meals.....		375,809		357,019		357,019
3. Aging Home-delivered Meals.....		94,065		94,191		94,191
4. Aging In-Home Services.....		9,263		9,263		9,263
5. Preventive Health Services.....		16,982		16,982		16,982
6. Training, Research, and Discretionary Programs.....		25,570		12,018		11,666
7. Grants to Indian Tribes.....		16,902		16,057		16,057
8. Aging Ombudsman.....		4,449		4,449		4,449
9. Aging Elder Abuse Prevention.....		4,732		4,732		4,732
10. Outreach, Public Benefit and Insurance Counseling.....		1,976		1,976		1,976
11. Federal Council on Aging.....		155		226		226
12. Federal Administration.....	177	15,953	177	16,300	177	16,789
13. White House Conference on Aging....		2,961		0		0
Total, Aging Services Programs.....	177	\$875,528	177	\$828,000	177	\$828,137

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Appropriations - FY 1997

est. \$828,137,000



Congregate Meals 43%

other = FCoA, Ombud, Benefit Couns

Budget Authority by Object

	1996 <u>Policy 1/</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Full-time equivalent employment.....	177	177	-0-
Full-time equivalent of overtime and holiday hours.....	1.0	1.0	-0-
Average SES salary.....	\$104,099	\$104,099	-0-
Average GS grade.....	12.9	12.9	-0-
Average GS salary.....	\$56,353	\$56,917	+\$564
Personnel compensation:			
Full-time permanent.....	10,403,000	10,513,000	+110,000
Other than full-time permanent.....	39,000	38,000	-1,000
Other personnel compensation.....	176,000	177,000	+1,000
Total.....	10,618,000	10,728,000	+110,000
Personnel Benefits.....	1,659,000	1,787,000	+128,000
Benefits to former personnel.....	325,000	425,000	+100,000
Travel and Transportation of Persons.....	374,000	383,000	+9,000
Transportation of Things.....	10,000	11,000	+1,000
Rent, Communications & Utilities:			
Rental payments to GSA.....	1,391,000	1,432,000	+41,000
Communications, utilities, & miscellaneous charges.....	309,000	318,000	+9,000
Printing and Reproduction.....	69,000	70,000	+1,000
Other Services:			
Project contracts.....			
Other Services.....	1,708,000	1,796,000	+88,000
Supplies and Materials.....	53,000	54,000	+1,000
Equipment.....	10,000	11,000	+1,000
Grants, Subsidies and Contributions.....	<u>811,474,000</u>	<u>811,122,000</u>	<u>-352,000</u>
Total budget authority by object.....	\$828,000,000	\$828,137,000	+\$137,000

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Administrative Costs

(Budget Authority)

	1996 Current <u>Estimate</u>	1997 <u>Estimate</u>	<u>Change</u>
Personnel compensation:			
Full-time permanent (11.1).....	10,403,000	10,513,000	+110,000
Other than full-time permanent (11.3).....	39,000	38,000	-1,000
Other personnel compensation (11.5).....	176,000	177,000	+1,000
Total Personnel Compensation (11.9).....	10,618,000	10,728,000	+110,000
Civilian Personnel Benefits (12.1).....	1,659,000	1,787,000	+128,000
Benefits to Former Personnel (13.0).....	325,000	425,000	+100,000
Travel (21.0).....	374,000	383,000	+9,000
Transportation of Things (22.0).....	10,000	11,000	+1,000
Communications, Utilities, & Miscellaneous Charges (23.3).....	309,000	318,000	+9,000
Printing and Reproduction (24.0).....	69,000	70,000	+1,000
Other Services (25.2).....	1,708,000	1,796,000	+88,000
Supplies and Materials (26.0).....	<u>53,000</u>	<u>54,000</u>	<u>+1,000</u>
Total.....	\$15,125,000	\$15,572,000	+\$447,000

Authorizing Legislation
(dollars in thousands)

	<u>1996 Amount Authorized</u>	<u>1996 Policy</u>	<u>1997 Amount Authorized</u>	<u>1997 Budget Request</u>
<u>Programs for the Elderly:</u>				
(1) Supportive Services and Centers, [Sec.303(a)(1) of the Older Americans Act of 1965, as amended].....	\$/	\$294,787	\$/	\$294,787
(2) Preventive Health Services [Sec.303 (f) of the Older Americans Act of 1965, as amended].....	\$/	16,982	\$/	16,982
(3) Aging Ombudsman Activities [Sec. 702(a) of the Older Americans Act of 1965 as amended]....	\$/	4,449	\$/	4,449
(4) Elder Abuse [Sec.702(b) of the Older Americans Act of 1965, as amended].....	\$/	4,732	\$/	4,732
(5) Nutrition:				
a) Congregate Meals [Sec. 303(b)(1) of the Older Americans Act of 1965, as amended].....	\$/	357,019	\$/	357,019

	<u>1996 Amount Authorized</u>	<u>1996 Policy</u>	<u>1997 Amount Authorized</u>	<u>1997 Budget Request</u>
b) Home-delivered Meals (Sec. 303(b)(2) of the Older Americans Act of 1965, as amended).....	a/	\$94,191	a/	\$94,191
(6) In-Home Services for the Frail Elderly (Sec. 303(d) of the Older Americans Act of 1965, as amended).....	a/	9,263	a/	9,263
(7) Outreach, Public Benefit and Insurance Counseling (Sec. 703(d) of the Older Americans Act of 1965, as amended).....	a/	1,976	a/	1,976
(8) Grants to Indian Tribes (Sec 633 of the Older Americans Act of 1965, as amended)....	a/	16,057	a/	16,057
(Indian Tribes- Part A).....	a/	(14,451)	a/	(14,451)
(Native Hawaiians- Part B).....	a/	(1,606)	a/	(1,606)
(9) Aging Training, Research and Discretionary Programs (Sec. 431(a) of the Older Americans Act of 1965, as amended).....	a/	12,018	a/	11,666

	<u>1996 Amount Authorized</u>	<u>1996 Policy</u>	<u>1997 Amount Authorized</u>	<u>1997 Budget Request</u>
(10) Federal Council on Aging, [Sec. 204(g) of the Older Americans Act as amended]....	a/	226	a/	226
(11) Program Direction/ Federal Administration.....	a/	16,300	a/	16,789
Unfunded authorizations:				
The Older Americans Act of 1965, as amended:				
(1) Board/Care Study [Sec.212].....	a/	---	a/	---
(2) Home Care Study [Sec.213].....	a/	---	a/	---
(3) School-based meals [Sec.338(b)(3)]	a/	---	a/	---
(4) Special Needs of Older Individuals [Sec.351]	a/	---	a/	---
(5) Supportive activities caretakers/frail older individuals [Sec.381]	a/	---	a/	---
(6) Vulnerable Elder Rights Protection [Sec.703(c)]	a/	---	a/	---
Total appropriation.....		\$828,000		\$828,137
Total, appropriation against definite authorizations.....		828,000		828,137

a/ Such sums as may be necessary for Fiscal Year 1996.

Appropriation History Table

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1988 1/	\$701,296,000	Defer	\$768,700,000	\$725,231,000
1989 1/	701,296,000	757,040,000	757,700,000	748,420,000
1990 1/	724,998,000	755,759,000	764,759,000	747,681,000
1991 1/	748,677,000	820,848,000	827,240,000	806,049,000
1992	809,049,000	809,049,000	867,874,000	846,597,000 2/
1993	850,693,000	838,228,000	850,693,000	838,676,000 3/
1994 3/	839,075,000	841,875,000	881,863,000	878,032,000 4/
1995	875,723,000	869,823,000	873,662,000	876,007,000 5/
1996	897,148,000	778,246,000	6/	828,000,000 7/
1997	828,137,000			

- 1/ These totals exclude Federal Administration for the Administration on Aging. Prior to FY 1992, AoA was a part of the former Office of Human Development Services, and AoA's Federal Administration funding was within OHDS' total Administration Cost.
- 2/ Excludes \$167,000 in across-the-board Program Direction cuts.
- 3/ Excludes \$6,767,712 of Section 511 PPA cuts, \$279,760 of Section 513 cuts, and \$241,000 of Section 216 cuts.
- 4/ Includes \$6,750,000 transfer from the Executive Office of the President for Emergency Disaster Relief.
- 5/ Excludes \$899,000 reduction in the Research & Demonstration program; \$88,000 reduction in Federal Administration; and \$229,000 in across-the-board reductions in Rent, Procurement, Awards, and Working Capital Fund.
- 6/ As of 3/13/96 the Senate has not acted, therefore Senate recommendations cannot be provided.
- 7/ This amount reflects the proposed Presidential Policy level. The annualized Congressional Continuing Resolution level is \$780,800,000 (P.L. 104-92 & P.L. 104-99).

ADMINISTRATION ON AGING
Justification
Account Summary

	<u>1996</u> <u>Policy</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
1. Supportive Services and Centers.....	294,787,000	294,787,000	-0-
2. Aging Congregate Meals.....	357,019,000	357,019,000	-0-
3. Aging Home-Delivered Meals.....	94,191,000	94,191,000	-0-
4. Aging In-Home Services.....	9,263,000	9,263,000	-0-
5. Preventive Health Services.....	16,982,000	16,982,000	-0-
6. Research, Training and Demonstration.....	12,018,000	11,666,000	-352,000
7. Grants to Indian Tribes.....	16,057,000	16,057,000	-0-
8. Aging Ombudsman.....	4,449,000	\$4,449,000	-0-
9. Aging Elder Abuse Prevention.....	4,732,000	4,732,000	-0-
10. Outreach, Public Benefit and Insurance Counseling...	1,976,000	1,976,000	-0-
11. Federal Council on Aging.....	226,000	226,000	-0-
12. Federal Administration.....	16,300,000	16,789,000	+ 489,000
Total.....	\$828,000,000	\$828,137,000	+ \$137,000
FTE	177	177	0

ADMINISTRATION ON AGING

General Statement

The Administration on Aging (AoA) is a component of the Office of the Secretary in the Department of Health and Human Services. Under the provisions of the Older Americans Act, the Administration on Aging serves as the focal point and advocate agency for older persons and their concerns at the Federal level. AoA works closely with its nationwide network of regional offices and State and Area Agencies on Aging to plan, coordinate, and develop community-level systems of services that meet the unique needs of individual older persons and their caregivers.

The fiscal year 1997 request for AoA is \$828,137,000. The request is based on a recognition that resources are constrained, therefore service levels supported in the FY 1996 policy amount will be maintained in FY 1997. The service delivery systems funded by AoA will target their efforts on the needs of socially and economically disadvantaged older persons, especially the low-income minority elderly.

Currently, there is under consideration reauthorizing legislation for the Older Americans Act that includes proposed transfers of \$150,000,000 to AoA from the administrative functions of the Department of Agriculture's Nutrition Program for the Elderly. In addition, the reauthorization proposes transfers of \$350,000,000 to AoA from the administrative functions from the Department of Labor's Community Service Employment for the Older Americans program. The appropriated funds would reside with the Department of Agriculture and the Department of Labor, respectively.

Aging Supportive Services and Senior Centers

Authorizing Legislation: Section 321 of the Older Americans Act of 1965, as amended.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy 1/</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$306,711,000	\$294,787,000	\$294,787,000	\$-0-

Purpose and Method of Operations:

The objectives of the Older Americans Act (OAA) and the vision for the Administration on Aging and the Department of Health and Human Services are to ensure that older Americans (present and future) have an independent, productive, healthy and secure life. Supportive services represent the cornerstone of a comprehensive and coordinated system of home and community-based services, which is needed to make the OAA objectives a reality in communities across the nation. Federal funds for Supportive Services and Senior Centers are allocated to the individual states through a statutory formula based primarily on each state's proportionate share of the total American population aged 60 and older. Other provisions in the formula provide minimum funding to smaller States and assure that no State receives less funds than it did in FY 1987.

The national network of 57 State Agencies on Aging, 657 Area Agencies on Aging and 25,000 service providers represent an experienced network in planning, coordinating and providing home and community-based services to older persons living in the community. This network continues to build upon the foundation provided by OAA resources to foster the enhancement of a comprehensive and coordinated system which is responsive to the needs of the elderly. As catalysts and brokers, State and Area Agencies on Aging use OAA funds to leverage state, local, and Federal resources to expand and improve services. This coordinated effort that includes local providers, area agencies, state agencies, and the Administration on aging have come to constitute the "aging network."

Each State Agency on Aging is required to have a State Plan approved by AoA as a prerequisite for receipt of funds. Based on an approved area plan, State Agencies on Aging award the funds to designated Area Agencies on Aging at the substate level. The Area Agencies on Aging make awards to local service provider agencies or, to insure a service or its quality, with State Agency approval, directly provide services to older persons.

All individuals age 60 and over are eligible for services, although the Older Americans Act directs that priority be given to serving those who are in greatest economic and social need, with particular attention to low-income minority older individuals. In FY '94 nearly 6.8 million older individuals received supportive services. Statistics on the characteristics of these older persons indicate that service is provided to the targeted groups in greater proportion than their percentage in the general population of older persons served. Of that number, 35% were frail and disabled, 19% were minority older persons and 40% were low-income older persons.

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

There are no mandatory fees in this program; however, older persons are encouraged to make voluntary contributions to help defray the cost of services. The statute requires that these contributions will be used to expand the number and quality of services. Local programs were able to provide additional services to older individuals as a result of approximately \$25 million in program income collected in FY 1994. In addition, volunteer support is an integral component of the service system.

Funding for this activity during the last five years has been as follows:

1992.....	\$299,238,000 ^{a/}
1993.....	\$296,844,000 ^{b/}
1994.....	\$306,711,000
1995	\$306,711,000
1996 Policy.....	\$294,787,000

^{a/} Reflects Sequester of 2.41% pursuant to P.L. 101-517.

^{b/} Reflects reprogramming of \$762,000 to the White House Conference on Aging.

Rationale for the Budget Funding Request

Funding of \$294,787,000 is requested for fiscal year 1997. This funding level is the same amount as the FY 1996 policy level. There continues to be a great need for supportive services and senior centers in local communities as they provide the fundamental core of a comprehensive and coordinated system of in-home and community-based services, including long-term care services. These services make a vital difference in the lives of older persons who are attempting to remain independent and to live in their homes and communities for as long as possible. About 6,000 senior centers across the nation received funding under the Title III program.

States are using the majority of these funds to support access to services, fill service gaps, and provide core in-home and community-based services. During FY 1994 information and assistance services were provided for over 3 million older persons and their caregivers. Over 1.5 million outreach contacts were made to identify older persons who were in need to gain access to needed services. Over 800,000 older persons received needed transportation services to their doctor, clinic or senior center. Hundreds of thousands of older persons received in-home services, such as homemaker and home health aides, personal care, and home repair/maintenance. Vulnerable older persons also were assisted through legal services, guardianship, escort, and placement services.

Because supportive services are designed to meet the priority needs of older persons in each community and are offered in close coordination with other resources at the local level, such as Medicaid waiver and State-funded programs, these services can be provided in the most responsive and cost-effective manner. For example, it is more cost effective to assist an older person who is released from the hospital after hip surgery with short term in-home services to augment caregiver support than to require this individual to go to a nursing home to recuperate. These services are designed to maximize informal support provided by caregivers and to enhance the capacity of the older individual to remain self-sufficient.

Congregate Nutrition Services

Authorizing Legislation: Section 331 of the Older Americans Act of 1965, as amended.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy 1/</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$375,809,000	\$357,019,000	\$357,019,000	\$-0-

Purpose and Method of Operations:

Federal funds for Congregate Nutrition Services are provided under Title III, Part C-1. The funds are awarded to State Agencies on Aging through the same formula used for all Title III funds, as described more fully in the discussion of supportive services. Congregate nutrition services funds are awarded by the State Agency on Aging to Area Agencies on Aging which, in turn, make awards to or contract with congregate nutrition service providers.

AoA has contracted with Mathematica Policy Research, Inc. to conduct a congressionally mandated evaluation of the OAA Nutrition Programs. Preliminary data from the evaluation will be cited in both this section and the FY 1997 Funding Request. Results of the evaluation are expected to be public late spring, 1996.

All older persons age 60 and over, and their spouses regardless of age are eligible for the OAA nutrition services. The OAA directs that priority be given to those who are in greatest economic and social need, with particular attention to low-income, minority older persons. Most recent data from the AoA State Performance Report for FY 1994 indicate that 127 million meals were served to 2,293,000 older persons. Statistics on the characteristics of these older persons follow and indicate that service is provided to targeted groups in greater proportion than their percentage in the general population. Of older persons served, 27% of these were frail and disabled; 43% were low-income; 43% were rural residents; 17% were minority; and 12% were low-income, minority.

Services are provided to groups of older people at senior centers and nutrition sites. The Congregate Nutrition Program is different than other food assistance programs such as food stamps because it provides a cooked, ready to eat meal to seniors in a group setting. Participation in a group setting reduces isolation and encourages continued physical and mental functioning. In addition, the setting is conducive to accessing and linking with other supportive community services. In comparison to home-delivered nutrition program participants, congregate participants are more able and healthy. For these individuals, the Congregate Nutrition Program functions as a health promotion/disease prevention program. The Congregate Nutrition Program also provides valuable opportunities to volunteer and give back to the community.

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Congregate Nutrition Service providers target special populations with increased needs through specific congregate programs such as a breakfast and dinner program in high-risk communities during the week and on weekends, use of soup kitchens to reach homeless elders, or use of a home luncheon program in a high-rise.

Although meals are the primary service provided, other nutrition services including nutrition screening, education, counseling, and outreach are provided. Congregate meals provided under the OAA must comply with the Dietary Guidelines for Americans and provide a minimum of 33% of the Recommended Dietary Allowances (RDA) if one meal is served; a minimum of 66% of the RDA if two meals are served; and 100% of the RDA if three meals are served. Service providers are encouraged to expand meal service to more than one meal per day, more than five days a week, to persons with increased needs. Where feasible and appropriate, meals are provided to meet the special health, religious, and ethnic requirements of participants.

There is substantial private sector/state/local community financial and volunteer support in the Congregate Nutrition Program. Although there are no fees or charges in this program, older persons are encouraged to contribute through volunteerism and financial support to help defray the cost of services. In FY 1994, Congregate Nutrition Program income, including contributions from service participants, was over \$101,000,000. Under current law, these contributions are used by local programs to expand services. Also, volunteers, many of them older program participants, perform essential program tasks such as managing nutrition sites, delivery of meals and record keeping, etc. Data indicate that about 20% of the cost of a meal is from participant contributions and that about 8% of the cost of a meal is from volunteer labor.¹ A significant finding is that for every \$1.00 in federal resources spent, the nutrition program leverages nearly \$2.00 in contributions, volunteer services, and state, local and private funds.¹

Funding for this activity during the past five years has been as follows:

1992.....	\$366,067,000a/
1993.....	\$363,235,000
1994.....	\$375,809,000
1995	\$375,809,000
- 1996 Policy.....	\$357,019,000

a/ Reflects reprogramming of \$933,000 to the White Conference on Aging.

¹ Ponza, M., et.al., Elderly Nutrition Program Evaluation Draft Final Report, Mathematica Policy Research, Inc., August, 1995.

Rationale for the Budget Request

Funding of \$357,019,000 is requested for FY 1997. This funding level is the same as the FY 1996 policy level. As stated in its strategic plan, the primary mission of the AoA is to ensure that older Americans have an independent, productive, healthy and secure life. Adequate nutritional status is essential to the well-being, health, independence and quality of life of all from well, healthy, more able older persons to frail, ill, functionally-impaired older persons. The Congregate Nutrition Program strives to provide a continuum of services to meet these individual needs. The amount of funding requested will allow the Congregate Nutrition Program to continue to address major difficulties faced by older persons which include:

- nutritional deficiencies due to inadequate income and/or lack of facilities to prepare food;
- isolation, which cuts older persons off from contact with others and is a barrier to accessing needed services;
- illness, disease, and other conditions which affect independence.

Health and nutrition studies indicate that:

- eight (8) of 10 leading causes of death are related to diet and nutrition;
- eighty-five (85) percent of older persons have a nutrition-related condition or chronic disease;
- nutritional status is a risk factor for and predictor of visits to the physician, hospital emergency room, and hospital admission and readmission; and
- access to and acquisition of adequate food and food insecurity are significantly related to income and poverty status with minority older people experiencing higher rates of food insecurity.

The objectives of this program are to provide healthful meals and related nutrition and supportive services to nutritionally at-risk older persons. As an integral component of a comprehensive and coordinated in-home and community-based service system, the Congregate Nutrition Program promotes health, reduces social isolation and links older persons to other supportive services and programs. The Congregate Nutrition Program assists older persons in remaining independent and at home and avoiding premature nursing home placement. It promotes disease prevention and treats nutrition related conditions and diseases thereby limiting use of more expensive health care services.

Congregate participants vary in demographic, income, and functional status. Data indicate that when compared to the U.S. elderly population, congregate participants are older (76 years old compared to 72 years), more likely to be female (69% compared to 58%), more likely to live alone (57% compared to 31%), more likely to be minority (27% compared to 14%), more likely to be poor (34% compared to 15%), or to be near-poor (79% compared to 38%), and to be low-income minority (15% compared to 4%). Approximately 8% of congregate participants have difficulty preparing meals and 13% have difficulty in grocery shopping.¹

The Congregate Nutrition Program reaches vulnerable older persons who manage chronic health conditions and are nutritionally at-risk. Data indicate that congregate participants have an average of 2.4 chronic health conditions; 25% of congregate participants have been hospitalized in the past year; 40% take 3 or more medications daily; 22% are at high nutritional risk and 40% are at moderate nutritional risk; 33% of congregate participants have a body mass index below 24 which is an indicator of malnutrition risk and 42% have a body mass index above 27 which is an indicator of obesity which is a risk factor for multiple chronic health conditions.¹

In addition, data indicate that the meals consumed by congregate participants are the participants primary source of nutrients for the day, providing almost half of needed nutrients. When compared with non-participants, dietary intake of participants as a percentage of the Recommended Dietary Allowances is 5 to 31% higher.¹

The Congregate Nutrition Program has a major impact on participants socialization and decreases isolation. The data indicate that about 25% of total social contacts are from program sources and that participants have 16% more social contacts than non-participants.¹

The Congregate Nutrition Program supports the Secretary's goal of fostering independence through empowering the people we serve. It is designed to maintain life, improve health, promote healthful lifestyles, enhance independence and self-sufficiency and address special health needs of older women and minority persons.

In 1992, the AoA and the Office of the Inspector General (OIG) completed a review of SUA's implementation of Title III of the OAA. For nutrition services, although some weaknesses were noted in the SUAs' guidance and assessment of AAAs, SUAs were found to be generally successful in implementing the nutrition requirements of the OAA. In FY 1995, the AoA regional offices provided additional assistance through state visits. In FY 1996, the state nutritionists met for the first time in 20 years to discuss program administration, operations, and program accountability. As a follow-up to the state nutritionist meeting, the AoA regional offices will be providing additional training and technical assistance to meet needs identified by the state nutritionists.

To measure program performance, the AoA is in the process of improving its data collection efforts through the National Aging Program and Information System (NAPIS) which will allow the AoA to improve the accuracy of the data collected on participants and services, enhance analysis of program performance and provide information to improve service targeting. As part of this on-going system, the AoA will be collecting data on the nutritional risk of the participants served.

Significant findings include that the Congregate Nutrition Program targets services to those most in need; has a major impact on participants' nutritional well-being and socialization; are efficient and cost effective; and is closely linked to home and community-based long-term care.¹

The requested funding allows Congregate Nutrition Services to continue to meet essential food, nutrition, and health service needs of older persons, fulfills the mission of the AoA and supports the Secretary's goals. It is consistent with supporting an alternative to institutional care, promotes health and fosters independence.

Home-Delivered Nutrition Services

Authorizing Legislation: Section 336 of the Older Americans Act of 1965, as amended.

<u>1995 Actual</u>	<u>1996 Policy 1/</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$94,065,000	\$94,191,000	\$94,191,000	\$-0-

Purpose and Method of Operations:

Federal funds for Home-Delivered Nutrition Services are awarded under Title III, Part C-2, to each State with an approved State Plan on Aging. Funds are distributed to the States according to the formula used for all Title III services, as described more fully in the discussion of supportive services. State Agencies on Aging make awards to Area Agencies on Aging, based on State-approved Area Plans. Area Agencies on Aging make awards to or contract with local service providers.

Administration on Aging is contracted with Mathematica Policy Research, Inc. to conduct a congressionally mandated evaluation of the OAA Nutrition Programs. Preliminary data from the evaluation will be cited in both this section and the FY 1997 Funding Request. Results of the evaluation are expected to be public late spring, 1996.

Home-Delivered Nutrition Services are provided to older persons, age 60 and older who are home-bound due to illness, disability or geographic isolation; a spouse of any age is eligible. The OAA directs that priority be given to those who are in greatest economic and social need, with particular attention to low-income, minority older persons. Most recent data from the AoA State Performance Report for FY 1994 indicate that 113 million meals were served to 877,000 older persons. Statistics on the characteristics of these older persons follow and indicate that service is provided to targeted groups in greater proportion than their percentage in the general population. Of older persons served, 75% of these were frail and disabled; 54% were low-income; 40% were rural residents; 18% were minority; and 14% were low-income, minority.

Services are provided to older people in their homes. Home-Delivered Nutrition Services is different than other food assistance programs such as food stamps which require that a person be able to obtain and prepare food. Recipients of Home-Delivered Nutrition Services usually have significant impairments in health and functional status that make acquiring and preparing food difficult. Frequent contact between the home-bound older person and the meal deliverer helps reduce isolation and allows for more frequent checking on the status of isolated home-bound older persons. Home-bound older persons are often linked to other community supportive services through an individualized assessment and intake process. The provision of Home-Delivered Nutrition Services provides respite to caregivers and assists caregivers in continuing to maintain older persons at home. Often the provision of a home-delivered meal is the essential service that prevents premature nursing home admission. For Home-Delivered Nutrition Services participants, these services serve health maintenance and rehabilitation functions.

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Because Home-Delivered Nutrition Program participants are more frail and impaired than Congregate participants, frequency and intensity of service may be different than for Congregate Nutrition Program participants. Home-delivered Nutrition Program participants may receive meals more than five days a week and more than one meal a day.

Although meals are the primary service provided, other nutrition services including nutrition screening, education, counseling, and outreach are provided. Home-delivered meals provided under the OAA must comply with the Dietary Guidelines for Americans and provide a minimum of 33% of the Recommended Dietary Allowances (RDA) if one meal is served; a minimum of 66% of the RDA if two meals are served; and 100% of the RDA if three meals are served. Service providers are encouraged to expand meal service to more than one meal per day, more than five days a week, to persons with increased needs. Where feasible and appropriate, meals are provided to meet the special health, religious, and ethnic requirements of participants.

There is substantial private sector/state/local community financial and volunteer support in the Home Delivered Nutrition Program. Although there are no fees or charges in this program, older persons are encouraged to contribute through volunteerism and financial support to help defray the cost of services. In FY 1994, Home-Delivered Nutrition program income, including contributions from program participants, was \$72,000,000. Under current law, these contributions are used by local programs to expand services. Also, volunteers, many of them older Congregate Nutrition Program participants, perform essential program tasks such as delivery of meals or record keeping. Data indicate that about 20% of the cost of a meal is from participant contributions and that about 9% of the cost of a meal is from volunteer labor.¹ A significant finding is that for every \$1.00 in federal resources spent, the nutrition program leverages nearly \$2.00 in contributions, volunteer services, and state, local and private funds.¹

Funding for this activity during the last five years has been as follows:

1992.....	\$89,603,000 ^{a/}
1993.....	\$89,659,000
1994.....	\$93,665,000
1995.....	\$94,065,000
1996 Policy.....	\$94,191,000

^{a/} Reflects reprogramming of \$228,000 to the White House Conference on Aging.

Rationale for the Budget Request

Funding of \$94,191,000 is requested for Home-delivered Nutrition Services in fiscal year 1997, the same as the 1996 policy level. As stated in its strategic plan, the primary mission of the AoA is to ensure that older Americans have an independent, productive, healthy and secure life. Adequate nutritional status is essential to the well-being, health, independence and quality of life of all from well, healthy, more able older persons to frail, ill, functionally-impaired older persons. The Home-Delivered Nutrition Program strives to

¹ Ponza, M., et.al., Elderly Nutrition Program Evaluation Draft Final Report, Mathematica Policy Research, Inc., August, 1995.

provide a continuum of services to meet these individual needs. The amount of funding requested will allow the Home-Delivered Nutrition Program to continue to address major difficulties faced by older persons which include:

- nutritional deficiencies due to inadequate income and/or lack of facilities to prepare food;
- isolation, which cuts older persons off from contact with others and is a barrier to accessing needed services;
- illness, disease, and other conditions which affect independence.

Health and nutrition studies indicate that:

- eight (8) of 10 leading causes of death are related to diet and nutrition;
- eighty-five (85) percent of older persons have a nutrition-related condition or chronic disease;
- nutritional status is a risk factor for and predictor of visits to the physician, hospital emergency room, and hospital admission and readmission; and
- access to and acquisition of adequate food and food insecurity are significantly related to income and poverty status with minority older people experiencing higher rates of food insecurity.

The objectives of this program are to provide healthful meals and related nutrition and supportive services to nutritionally at-risk older persons. As an integral component of a comprehensive and coordinated in-home and community-based service system, Home-Delivered Nutrition Program promotes health, reduces social isolation, links older persons to other supportive services and programs and assists caregivers of functionally-impaired older persons. The Home-Delivered Nutrition Program assists older persons in remaining independent and at home, and avoiding premature nursing home placement. It promotes disease prevention and treats nutrition related conditions and diseases, thereby limiting use of expensive health care services. AoA State Performance Report data indicate that the proportion of home-delivered meals is increasing compared to congregate meals.

Home-delivered participants vary in demographic, income, and functional status. Data indicate that when compared to the U.S. elderly population, home-delivered participants are older (78 years old compared to 72 years), more likely to be female (70% compared to 58%), more likely to live alone (60% compared to 31%), more likely to be minority (25%

compared to 14%), more likely to be poor (48% compared to 15%), or to be near-poor (90% compared to 38%), and to be low-income minority (16% compared to 4%). Approximately 41% of congregate participants have difficulty preparing meals and 64% have difficulty in grocery shopping. Home-delivered participants have an average of 3.8 functional impairments. About 46% of home-delivered participants leave the house about once a week.¹

The Home-Delivered Nutrition Program reaches vulnerable older persons who manage chronic health conditions and are nutritionally at-risk. Data indicate that home-delivered participants have an average of 3 chronic health conditions; 43% of home-delivered participants have been hospitalized in the past year; 61% take 3 or more medications daily; 48% are at high nutritional risk and 40% are at moderate nutritional risk; 47% of home-delivered participants have a body mass index below 24 which is an indicator of malnutrition risk and 32% have a body mass index above 27 which is an indicator of obesity which is a risk factor for multiple chronic health conditions.¹

Data indicate that the meals consumed by home-delivered participants are their primary source of nutrients for the day. When compared with non-participants, dietary intake of participants as a percentage of the Recommended Dietary Allowances is 5 to 31% higher.¹

The Home-Delivered Nutrition Program has a major impact on participants socialization and decreases isolation. Data indicate that about 25% of total social contacts are from program sources and that participants have 18% more social contacts than non-participants.¹

The Nutrition Services Program supports the Secretary's goal of fostering independence through empowering the people we serve. It is designed to maintain life, improve health, promote healthful lifestyles, enhance independence and self-sufficiency and address special health needs of older women and minority persons.

In 1992, the AoA and the Office of the Inspector General (OIG) completed a review of SUA's implementation of Title III of the OAA. For nutrition services, although some weaknesses were noted in the SUAs' guidance and assessment of AAAs, SUAs were found to be generally successful in implementing the nutrition requirements of the OAA. In FY 1995, the AoA regional offices provided additional assistance through state visits. In FY 1996, the state nutritionists met for the first time in 20 years to discuss program administration, operations, and program accountability. As a follow-up to the state nutritionist meeting, the AoA regional offices will be providing additional training and technical assistance to meet needs identified by the state nutritionists.

To measure program performance, the AoA is in the process of improving its data collection efforts through the National Aging Program and Information System (NAPIS) which will allow the AoA to improve the accuracy of the data collected on participants and services, enhance analysis of program performance and provide information to improve service targeting. As part of this on-going system, the AoA will be collecting data on the nutritional risk of the participants served.

Significant findings include that the Home-Delivered Nutrition Program targets services to those most in need; has a major impact on participants' nutritional well-being and socialization; are efficient and cost effective; and is closely linked to home and community-based long-term care.¹

The requested funding allows Home-Delivered Nutrition Services to continue to meet essential food, nutrition, and health service needs of older persons, fulfills the mission of the AoA and supports the Secretary's goals. It is consistent with supporting an alternative to institutional care, promotes health and fosters independence.

Nutrition Program for the Elderly
Home Delivered and Congregate Meals
 Fiscal Years 1980-1992
 (Meals in Millions)

Fiscal Year	Total Meals	Congregate Meals	Home Delivered Meals	Home-Delivered as a Percent of Total Meals
1980	168.4	132.0	36.4	22%
1981	187.9	142.6	45.3	24%
1982	190.8	140.3	50.5	26%
1983	202.6	145.1	57.5	28%
1984	214.1	147.4	66.7	31%
1985	225.4	149.9	75.5	33%
1986	228.9	149.1	79.8	35%
1987	232.6	146.7	85.9	37%
1988	241.9	147.2	94.7	39%
1989	237.5	142.5	95.0	40%
1990	244.2	142.4	101.8	42%
1991	238.4	136.7	101.7	43%
1992	240.4	134.8	105.6	44%
1993	228.9	126.4	102.5	45%
1994	239.8	126.7	113.1	47%

In-Home Services for Frail Older Individuals

Authorizing Legislation: Section 341 of the Older Americans Act of 1965, as amended.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy 1/</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$9,263,000	\$9,263,000	\$9,263,000	\$-0-

Purpose and Method of Operation:

Federal funds for in-home services for frail older individuals are provided under Title III, Part D. The funds are awarded to State Agencies on Aging through the same formula used for all Title III funds, as described in the discussion of Supportive Services. In making funds available for in-home services at the sub-State level, each State agency develops eligibility criteria which take into account (1) age; (2) greatest economic need; (3) non-economic factors contributing to frailty; and (4) non-economic and non-health factors contributing to the need for in-home services.

At the discretion of state and area agencies on aging, in-home services can include:

- (1) homemaker and home health aides;
- (2) visiting and telephone reassurance;
- (3) chore maintenance;
- (4) in-home respite care for families, and adult day care as a respite service for families;
- (5) minor modification of homes that is necessary to facilitate the ability of older individuals to remain at home and that is not available under other programs; and
- (6) personal care services.

Funding for this activity during the last five years has been as follows:

1992.....	\$6,898,000 ^{a/}
1993.....	\$7,075,000
1994	\$7,075,000
1995	\$9,263,000
1996 Policy.....	\$9,263,000

^{a/} Reflects reprogramming of \$18,000 to the White House Conference on Aging.

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Rationale for the Budget Request

Funding of \$9,263,000 is requested for fiscal year 1997, the same as the FY 1996 policy level.

While most older Americans over the age of sixty live independently, many are at risk of losing their self-sufficiency. Those at risk may have physical or mental impairments such that they require help with day-to-day tasks like bathing, dressing, cooking, essential shopping, and household maintenance. They also may have limited incomes and may not be able to afford in-home services. Older minority persons face additional barriers related to accessing services.

Since the passage of the Older Americans Act (OAA) in 1965, all persons age sixty or over have been eligible to receive services under the Act, without any restrictions based on income or other personal characteristics. Despite this all inclusive eligibility, the Act requires that special consideration be given to targeting those older individuals who are in "greatest economic and social need" as defined in section 302 of the Act. The term "greatest economic and social need" means the need caused by noneconomic factors which include physical and mental disabilities, language barriers, and cultural, social, or geographical isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks or which threatens such individual's capacity to live independently.

This program directly addresses the needs of vulnerable older people by providing services to them and their caregivers in their homes. Home-based care enables older persons to maintain as much of their independence as possible and to avoid or delay institutionalization. These services are a critical component of home and community-based long-term care services provided to frail older persons, including those who are victims of Alzheimer's Disease. Assistance provided to these vulnerable persons helps prevent the need for more costly health and institutional care.

This program also supports the families of older individuals. Approximately eighty percent of personal care needs are met through families. Assistance provided to family caregivers also helps prevent the need for more costly health and institutional care.

The following reveal the extent of the problem:

- About 5.8 million noninstitutionalized older people 65 years and above have physical impairments.
- About 4.3 million people over the age of 65 have some difficulty performing at least one activity of daily living.
- A probable 3.4 million noninstitutionalized older people have Alzheimer's Disease and related disorders with neurological and organic brain dysfunction.
- About 2.5 million older minority members have incomes less than 200 percent of the poverty level.

Finally, the impact of this program on assisting older individuals who are frail to continue to stay in their communities and out of expensive institutions, cannot adequately be measured in terms of the immediate outlays. The cost savings cannot be measured in those communities where institutionalization is especially expensive.

Preventive Health Services

Authorizing Legislation: Section 381 of the Older Americans Act of 1965, as amended.

1995 <u>Actual</u>	1996 <u>Policy 1/</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
\$16,982,000	\$16,982,000	\$16,982,000	\$-0-

Purpose and Method of Operations:

Federal funds for Preventive Health Services are provided under Title III, Part F. The funds are awarded to State Agencies on Aging through the same formula that is used for all Title III funds, as described more fully in the discussion of Supportive Services. Preventive Health Services funds are awarded by the State Agency on Aging to Area Agencies on Aging which, in turn, make awards to other community organizations and agencies. The State Agency on Aging is required to give priority to areas of the state in which the older residents are medically underserved and have the greatest economic need.

The Preventive Health Services under this part may include: routine health screening (hypertension, glaucoma, cholesterol, cancer, vision and hearing screening); group exercise programs; home injury control services, including screening of high-risk home environments and educational programs on injury protection in the home environment; nutritional counseling and educational services; screening for the prevention of depression; coordination of community mental health services, educational activities, and referral to psychiatric and psychological services; educational programs on the benefits and limitations of Medicare and various supplemental insurance coverage, including individual policy screening and health insurance-needs counseling; and counseling regarding follow up health services based on any of the services provided for above.

Funding for this activity during the last five years has been as follows:

1992.....	\$16,875,000g/
1993.....	\$16,864,000
1994.....	\$17,032,000
1995.....	\$16,982,000
1996 Policy.....	\$16,982,000

g/ Excludes a rescission of \$125,000.

Rationale for the Budget Request

Funding of \$16,982,000 is requested for fiscal year 1997, the same as the FY 1996 policy level. This funding level will support further development of preventive health services to promote and improve the well-being of the nation's elderly. Funds appropriated for this activity are part of comprehensive and coordinated service systems targeted to those elderly most in need.

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

These services support the Secretary's theme of preventing future problems and emphasizing early intervention. While many people think of health problems in old age as inevitable, a substantial number of ailments are either preventable or can be controlled. Preventive health services encourage older persons to live healthy lifestyles which can reduce the incidence of costly and debilitating illnesses such as heart disease and osteoporosis.

Healthy People 2000, the National Health Promotion and Disease Prevention Objectives for the decade list three principal goals: 1) increase the span of healthy life; 2) reduce health disparities; and 3) provide access to preventive services for all Americans. Eighty-two specific objectives for older persons address physical activity, nutrition, tobacco, alcohol and other drugs, mental health and disorders, violence and abuse, environmental health, food and drug safety, oral health, heart disease and stroke, cancer, diabetes and chronic disabling conditions, immunization and infectious diseases, and clinical preventive services. The opportunities presented by these objectives can be summarized, in part, by the goal of a target for reducing the proportion of people aged 65 and older who are limited in two or more activities of daily living. Through continued funding of Title III-F, the Administration on Aging can continue to work toward this and other specific Healthy People 2000 goals.

Aging Training, Research, and Discretionary Programs

Authorizing Legislation: Sections 309 and 431 of the Older Americans Act, as amended.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy 1/</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$25,570,000	\$12,018,000	\$11,666,000	-\$352,000

Purpose and Method of Operation

The Discretionary Funds Programs authorized by Title IV of the Older Americans Act constitute the major research, demonstration, training, and information dissemination effort of the Administration on Aging. These programs are aimed at expanding our understanding of older persons, developing innovative model programs, training personnel for service in the field of aging, and providing technical assistance and information to the aging network and to others who work with older persons.

Under the mandate of the Title IV program, the Administration on Aging (AoA) has had the resources to emulate the private sector with an applied research, demonstration, and development strategy that develops, tests, and incorporates new ideas and innovative best practices at the state and local levels. As the applied research and development (R&D) program of the aging network, Title IV has been and continues today as the testing ground for nutrition programs, home health services, legal services, transportation, respite care, adult day care, reverse mortgages, and many other innovative services which were funded in order to determine how effectively they would promote and protect the independence, rights, and dignity of older Americans in their communities.

Grants or contracts may be made to any public or non-profit agency, organization, or institution. Among those agencies and institutions funded are colleges, universities, State and Area Agencies on Aging, and other organizations representing and/or serving older people.

Funding for this activity during the last five years has been as follows:

1992.....	\$25,768,000
1993.....	\$25,692,684
1994.....	\$25,830,000
1995.....	\$25,570,000
1996 Approp./CR.....	\$ -0-
1996 Pres.Policy	\$12,018,000

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Rationale for the Budget Request

The fiscal year 1997 request for Training, Research and Discretionary activities is \$11,666,000, a decrease of \$352,000 from the current estimate for this program in FY 1996. The estimates for FY 1996 and FY 1997, each of which represents over a 50% decrease from the Title IV budget levels of prior years, are tempered by an understanding of contemporary budget realities and the greater priority on providing services to the elderly under Older Americans Act programs. However, this does not lessen the importance of investing in this vital discretionary program in preparing the nation for a doubling of the older population. Title IV remains critical to determining how best to serve older persons and their families, now and in the 21st century, through applied research, innovative model programs, better trained personnel, and timely technical assistance and information.

Principal current examples of Title IV initiatives include: the National Resource and Policy Centers in long-term care, nutrition, long-term care ombudsman, elder abuse prevention, housing, and older women; a National Aging Information Center; a National Academy on Aging; two National Resource Centers on Native American Elders; and career preparation programs in the field of aging. The following program priorities will guide the allocation of FY 1997 Title IV funds:

- 1) Expanding the current system of consumer directed home and community-based long-term care for older persons and others with disabilities, with a special emphasis on Alzheimer's Disease victims and their caregivers;
- 2) Developing a blueprint for the retirement of the baby-boom generation;
- 3) Protecting older persons from crime, violence, abuse, and exploitation; and
- 4) Advancing our understanding of how to better serve minority elderly.

FY 1996 Current Estimate

The indicated FY 1996 Appropriation/Continuing Resolution level for Title IV is zero funding. Thus far in FY 1996, the AoA has been governed by a series of Continuing Resolutions which treat Older Americans Act programs as one overall program account and which thereby limit funding to the levels (prorated) set forth in the Fiscal Year 1996 Appropriations Bill passed by the House of Representatives.

However, rather than the program being zeroed out, it is far more likely that, when the March 15, 1996 Continuing Resolution comes up for consideration by Congress, provision will be made for Title IV funding in FY 1996 at a level approaching \$12-15 million. That more probable outcome is reflected in the FY 1996 President's Policy/Current Estimate of \$12,018,000.

Aging Grants to Indian Tribes and Native Hawaiian Organizations

Authorizing Legislation: Section 833 of the Older Americans Act of 1965, as amended.

1995 <u>Actual</u>	1996 <u>Policy 1/</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
\$16,902,000	\$16,057,000	\$16,057,000	\$-0-

Purpose and Method of Operations

Title VI, Grants to Native Americans, currently provides grants to Indian tribal organizations, Alaskan Native organizations, and non-profit groups representing Native Hawaiians to provide supportive and nutrition services, including both congregate and home delivered meals, to older Native Americans. These services respond to the cultural diversity of Native Americans and are essential components of comprehensive community based services, including home and community based long term care. A funding formula, based on the Tribal, Native Alaskan or Hawaiian Native population, age 60 and older, is used to distribute funds. In the past, grant awards have ranged from \$49,000 for Tribes with populations of between 50 and 100 elders, to \$125,000 for Tribes with populations over 1,501.

Funding for this activity during the past five years have been as follows:

1992.....	\$15,086,000 _{a/}
1993.....	\$15,110,000
1994.....	\$16,902,000
1995.....	\$16,902,000
1996 Policy.....	\$16,057,000

_{a/} Reflects reprogramming of \$38,000 to the White House Conference on Aging.

Rationale for the Budget Request

Funding of \$16,057,000 is requested for fiscal year 1997, the same as the 1996 policy level. Native Americans in general, and older Native Americans in particular, are among the most disadvantaged groups in the U.S. Although only 5.8 percent of the American Indian and Alaska Native population is age 65 and older, 26.5 percent of those age 65-74 and 34.7 percent of those aged 75 years old over were below the poverty level in 1990. Low incomes, as well as several other factors such as geographical isolation, breakdown of traditional family structure, and physical and mental disability can lead to decreased consumption of quality foods. A recent study of elderly Navajo identified a high prevalence of chronic protein malnutrition. The 1990 Census indicated that social isolation was high

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

among the American Indian and Alaskan Native population, with 37 percent of females and 19 percent of males over age 65 living alone. Poverty, malnutrition, and social isolation are all recognized as risk factors for disease and disability. Just as the absence of social support tends to increase disease and disability, its presence may hasten recovery and help to maintain health. In recent testimony before the Senate Special Committee on Indian Affairs, the National Association Title VI Directors stated that an increasing number of Indian elders relying on Title VI meals as their main meal of the day, there is an increasing need for special diets among Indian elders to prevent or delay the complications of diabetes, hypertension and heart disease, and that the most cost effective solution to long term care is prevention, and prevention is closely related to quality meals and in-home services such as homemaker, home health aid, chore assistance, and friendly visitation.

Long-Term Care Ombudsman Program

Authorizing Legislation: Section 702 of the Older Americans Act of 1965, as amended

<u>1995 Actual</u>	<u>1996 Policy 1/</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$4,449,000	\$4,449,000	\$4,449,000	\$-0-

FY 1997 Funding Request

Funding of \$4,449,000 is requested for the Ombudsman Program for fiscal year 1997. This is the same amount of funding under Title VII of the Older Americans Act which was provided for the program in the FY 1996 policy level.

Ombudsman programs in all States, Puerto Rico and the District of Columbia serve the nation's 1.5 million nursing home residents, who are the most frail and vulnerable group in the long-term care system. To the extent resources permit, the program also serves residents of board and care homes and similar adult care facilities. Ombudsman staff and volunteers:

- help residents and their families resolve complaints related to their care;
- promote policies and practices needed to improve the quality of care and life in long term care facilities;
- educate both consumers and providers about residents' rights and good care practices; and
- work to reduce and prevent both resident abuse and costly fraud against the Medicare and Medicaid programs.

In 1994, States reported that 839 paid staff and 6,591 volunteers serve the program. State Ombudsman reports provided the following additional data on the nationwide program:

- 565 local or regional ombudsman programs
- 176.6 thousand people who filed complaints
- 207.6 thousand complaints filed
- 74% of complaints resolved
- \$41.8 million total funding (60% Federal; 40% State and local)

While these figures represent a sizable ombudsman network nationwide, the numbers of local programs, staff and volunteers are insufficient to meet the demand for ombudsman assistance with the myriad of questions and problems residents and their loved ones have regarding long-term care facilities. As the population ages, the numbers of older people living in long term care facilities continues to increase, and so does the need for ombudsman services.

1/ Based on level of the ninth CR, including an incremental policy adjustment.

Current legislative proposals to roll back many of the Federal nursing home standards contained in the Nursing Home Reform Act of 1987 (OBRA '87) and reduce the Federal enforcement role make the Ombudsman program all the more essential in protecting residents and advocating on their behalf at the state level.

The following other recent developments underscore the crucial role ombudsmen play in the long-term care system and the need for sufficient resources to enable them to meet the demands which are being put upon them:

- **Consumer Report Article**

An August 1995 Consumer Reports article on selecting nursing homes stated, "The best advice we were able to get came from state or county ombudsmen, officials who resolve complaints and advocate on behalf of nursing home residents." The article provided a list of State ombudsmen. Calls to these offices have increased over the usually heavy volume since publication of the article, reflecting the public's need for the type of information and assistance long term care ombudsmen provide.

- **Institute of Medicine Recommendation**

A January 1995 report on the Ombudsman Program by the Institute of Medicine (IOM) found that ombudsmen make a valuable contribution in the institutional long term care arena but that the program lacks sufficient funding to adequately perform its mandated functions. The IOM Committee recommended funding to support one FTE ombudsman position per 2,000 long-term care beds, an increase of nearly 26% over the current estimated national average of 1 per 2,700 beds. (They estimated that the current national median is 1 per 5,276 beds and that some State ombudsman programs would need funding increases of more than 200% to adequately perform their functions.) The Committee recommended an increase in Federal funding for the program to \$39.5 million (adjusted for inflation) by FY 1998.

- **Operation Restore Trust: Ombudsman Role in Combatting Fraud and Abuse**

Ombudsmen have been designated as part of the core team for Operation Restore Trust (ORT), a two year Departmental demonstration designed to reduce and prevent Medicare and Medicaid fraud and abuse in five states. Operation Restore Trust funds support work in the five designated states; however, the "Fraud Alerts" which are disseminated nationwide as part of ORT and the national fraud and abuse hot line are generating increased referrals to ombudsman programs in all states. This, coupled with the increased demand from the Consumer Report article, is inundating some programs. Steady funding is required to ensure that staff are available to meet the growing need.

Investment in ombudsman staff and volunteers can reap substantial savings in public dollars in the long term. Effective ombudsman work helps improve patient care and prevent costly hospitalization. Ombudsman networks can and do help identify, report and prevent fraud against Medicare and Medicaid.

Ombudsmen also help improve the quality of life for residents. The IOM Committee reported:

Through systemic advocacy work and educational efforts, the State programs, individually and collaboratively, have brought to the attention of State and Federal policymakers, regulatory agencies and provider organizations a host of conditions that can and should be changed to improve the health, safety, rights and welfare of Long-Term Care (LTC) residents. Examples of changes advanced or promoted by ombudsman programs (often in conjunction with other organizations) include: enactment of the Nursing Home Reform Law of 1987; increased personal needs allowances; protections from involuntary discharge and room transfers; reduced use of physical restraints; improved building and safety standards; increased state funding for inspection and surveying of LTC facilities; reduced use of psychotropic medications; better licensing oversight of health care professionals; increased use of advance directives; stronger LTC staff competencies and sensitivities; and empowerment of residents through stronger resident and family governance structures.

Lack of Title VII funding in FY 1996 is severely curtailing program activity in those states which rely heavily on Title VII funding for their ombudsman programs. If these funds are not restored in FY 1997, the capacity of the nationwide program will begin to decline at the same time the need for ombudsman services is increasing.

Prevention of Abuse, Neglect, and Exploitation

Authorizing Legislation: Section 721 of the Older Americans Act of 1965, as amended.

<u>1995 Actual</u>	<u>1996 Policy 1/</u>	<u>1997 Estimate</u>	<u>Increase or Decrease</u>
\$4,732,000	\$4,732,000	\$4,732,000	\$-0-

Purpose and Method of Operation:

The 1992 Amendments to the Older Americans Act established a new Title VII for carrying out vulnerable elder rights protection activities, including the prevention of abuse, neglect and exploitation of older individuals, and training for persons involved in servicing victims.

The Older Americans Act defines elder abuse as abuse, neglect, and exploitation. The types of abuse covered by this definition include physical abuse; sexual abuse; psychological or emotional abuse; financial or material exploitation of funds, property or possessions; caregiver neglect (willful or non-willful), and self-neglect (failure to provide for oneself). Some of these types of elder abuse are criminal acts and some are non-criminal.

The Prevention of Abuse and Neglect funds are allocated to states according to the statutory formula outlined in the 1992 amendments to the Older Americans Act for all Title VII programs. Although States may elect to retain the funds at the State level, many States continue to distribute the funds on a formula basis to the Area Agencies on Aging, as they were required to do under Title III, Part G. To help assure that Prevention of Abuse and Neglect Program funds are used in the most effective manner, the Administration on Aging has provided Research, Training and Demonstration resources to support the establishment and operation of a National Center on Elder Abuse. The Center provides training, technical assistance, up-to-date program information, and reports on best practices to state and community programs in addressing elder abuse problems.

Funding for this activity during the past five years has been as follows:

1992.....	\$4,427,000 ^{a/}
1993.....	\$4,348,000
1994.....	\$4,648,000
1995.....	\$4,732,000
1996 Policy.....	\$4,732,000

^{a/} Reflects reprogramming of \$21,000 to the White House Conference on Aging.

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Rationale for the Budget Request

Funding of \$4,732,000 is requested for the Prevention of Abuse and Neglect Program for fiscal year 1997. This request is the same as the FY 1995 appropriation and the FY 1996 policy level. It is intended to maintain clear indication to the aging network, the adult protective services agencies, the law enforcement community, the domestic violence constituency, and others that AoA shares their conviction that crime, violence, and abuse against the elderly is a serious national concern.

FY 1997 funds will be used to support states and localities in continuing the educational and training efforts to (1) increase the preparedness of citizens and professionals to detect elder abuse early and prevent it from reoccurring; and (2) increase the range of professions involved in protecting potential victims. The funds will support State programs to promote and improve coordinated statewide and local elder abuse prevention systems. The funds will support activities that enhance and coordinate the services of adult protective, aging, law enforcement, criminal justice, domestic violence, and health services to meet the large and growing need for reaching and assisting older persons who are victims or at risk for becoming victims of all forms of elder abuse, including its criminal forms. Older victims often do not know about the remedies open to them when they are suffering abuse. Moreover, potential remedies and responses remain limited in far too many communities. Chapter 3 funds support activities that help older persons access and enter the abuse prevention system and receive protection.

Victimization data on crimes against older citizens and elder abuse are incomplete, but advocates for the elderly agree that incidents are substantially underreported and undetected. State reports of all types of elder maltreatment occurring in domestic settings has increased by 106% over the period of 1986 to 1994. A report on elder abuse by the Department of Human Services, Office of the Inspector General and a hearing by the Select Committee on Aging, U.S. House of Representatives, provides estimates that one and one-half (1.5) million elderly people are abused annually. To gain a fuller understanding of this national problem, the Administration on Aging and the Administration for Children and Families undertook, in late Fiscal Year 1994, to support a three-year study that will measure the incidence of elder abuse, neglect, and exploitation, a study now being carried out by the National Center of Elder Abuse.

Outreach, Public Benefits and Insurance Counseling

Authorizing Legislation: Section 741 of the Older Americans Act of 1965, as amended.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy 1/</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$1,976,000	\$1,976,000	\$1,976,000	\$-0-

Purpose and Method of Operations

The 1992 Amendments to the Older Americans Act established a new Title VII for carrying out vulnerable elder rights protection activities, including outreach, public benefits, and insurance counseling services to persons who may be eligible for assistance under other public and private programs. This program builds upon and expands a separate outreach assistance program that was originally authorized by the 1987 amendments but never funded. Under prior law, funds were meant to enable States to provide outreach and counseling to seniors regarding eligibility and enrollment in public assistance programs such as Medicaid, SSI, and food stamps. The 1992 Amendments expanded the counseling role of States to provide information to older persons about Medigap insurance policies, long-term care insurance, life insurance, and pensions.

Funding for this activity during the past five years has been as follows:

1992.....	\$ -0-
1993.....	\$ -0-
1994.....	\$2,000,000
1995.....	\$1,976,000
1996 Policy.....	\$1,976,000

Rationale for the Budget Request

Funding of \$1,976,000 is requested for Outreach, Public Benefits and Insurance Counseling for fiscal year 1997. This request is for the same funding level as the FY 1996 policy level. This program was funded for the first time in fiscal year 1994. Funds appropriated, as authorized by the act, will be used to supplement any funds that are currently expended for similar purposes under any Federal, State, or local programs offering similar services. Thus the FY 1997 funding request will build upon, not supplant, the current level of services.

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Federal Administration:

	1995 <u>Actual</u>	1996 <u>Policy 1/</u>	1997 <u>Estimate</u>	Increase or <u>Decrease</u>
Amount	\$15,953,000	\$16,300,000	\$16,789,000	+ \$489,000
FTE Ceiling	177	177	177	177

Purpose and Method of Operation:

Salaries and related expenses necessary to provide administrative and management support for all Administration on Aging (AoA) programs, are included in the Federal Administration account. Allocations for personal services, travel, supplies, equipment and other costs are made by the Office of Administration and Management to all headquarters and regional staff offices within AoA.

Funding for this activity during the past five years has been as follows:

1992.....	\$16,418,000
1993.....	\$15,978,000
1994.....	\$15,990,000
1995	\$15,953,000
1996 Policy.....	\$16,300,000

Rationale for the Budget Request

The FY 1997 request of \$16,789,000 is a net increase of \$489,000 over the FY 1996 policy level. The additional amount requested for the Federal Administration activity is needed to support the full funding of 177 full-time equivalent positions including funds to cover built-in increases such as annualization of the pay raises, hardware and software upgrades to support the Information Resource Management efforts for AoA's "Rightsizing" initiative and modest amounts for increasing costs of rent, postage and other administrative costs.

The Administration on Aging's relatively small staff is responsible for overseeing a vast network of 57 State units, 228 Indian tribal organizations, 670 senior centers and more than 27,000 service providers throughout the country. The AoA provides the bulk of its resources to services to older persons and their families and has kept to a minimum staffing requirements (and has reduced staff in keeping with downsizing efforts). The 177 FTEs provide the critical function of oversight of programs and grants, accountability in the use of dollars and ensuring that the state and local agencies and providers are utilizing funds properly, and in providing the policy and programmatic leadership at the national level.

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

Federal Council on the Aging

Authorizing Legislation: Section 204 of the Older American Act of 1965, as amended.

<u>1995</u> <u>Actual</u>	<u>1996</u> <u>Policy 1/</u>	<u>1997</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
\$155,000	\$226,000	\$226,00	\$-0-

Purpose and Method of Operations

The Federal Council on the Aging (FCoA) is the citizen advisory agency within the executive branch charged with advising and assisting the President on the special needs and characteristics of older Americans. It is comprised of fifteen members, five of whom are appointed by the President, five by the Senate, and five by the House of Representatives. By statute, at least nine of the members themselves must be older persons.

Mandates of the FCoA include: advising the President on matters related to the special characteristics of older persons; convening quarterly public meetings and conducting public hearings; reviewing and evaluating policies to assess their effectiveness and to promote better coordination between and across government agencies; serving as spokespersons on behalf of older Americans and their families by making recommendations about Federal policies and programs; informing the public by conducting or commissioning studies and issuing reports; serving as appointees to the Advisory Committee of the White House Conference on Aging; and issuing an annual and interim report to the President on key findings and priority recommendations.

Funding for this activity during the last five years has been as follows:

1992	\$180,000
1993	\$178,000
1994	\$177,000
1995	\$155,000
1996 Policy.....	\$226,000

Rationale for the Budget Request

Funding of \$226,000 is requested for fiscal year 1997. This funding level is the same as the FY 1996 policy amount. The amount of funding requested will allow the Council to continue the following activities:

- Support the statutorily mandated quarterly meetings of the Council

1/ Based on levels of the ninth CR, including an incremental policy adjustment

- Conduct several studies and publications, including a special report prepared in conjunction with the National Institute of Mental Health to better inform service providers in community mental health centers about issues pertaining to older consumers and their families. These activities will seek to prevent future costs and problems by helping to train practitioners in the field of aging to better assist older persons with mental health needs (existing funding does not support the publication and distribution of these informational and training materials).
- Enable the Council to meet in Subcommittee sessions to provide program and policy leadership on consumer-oriented materials, including home and community-based long-term care, nutrition, productive aging, and volunteerism.

The Federal Council on Aging has developed a set of initiatives which are designed to work in joint partnership with the President, the Department of Health and Human Services, the Administration on Aging, and other federal agencies reach out to and empower older persons on priority issues such as long-term care, nutrition, elder abuse, productive aging, and greater personal and lifelong planning for retirement. The major components of these cooperative efforts include:

- Joining in partnership with the Department of Health and Human Services in focusing increased attention on preventing elder abuse and domestic violence against older persons. The Council intends to use its visibility in local communities to reach out to older persons who may be at particular risk of domestic violence and to better inform the senior citizen community about sources of assistance.
- Working with the Administration on Aging, the Social Security Administration, and the Department of Labor to better inform persons of all ages about the need for early and comprehensive planning for retirement and successful aging.
- Playing a leadership role in following up on the major recommendations from the White House Conference on Aging and assisting in promoting and publicizing new initiatives to older persons in their communities.

ADMINISTRATION ON AGING
Detail of Full-Time Equivalent Employment
Federal Administration

	FY 1995 <u>Actual</u>	FY 1996 <u>Estimate</u>	FY 1997 <u>Estimate</u>
Executive Level IV.....	\$115,703	\$115,703	\$115,703
ES-4.....	\$111,842	\$111,842	\$111,842
ES-2.....	203,024	315,867	315,867
ES-1.....	193,674	100,530	100,530
Total - ES Salary.....	\$508,540	\$528,239	\$528,239
GS-15.....	\$1,839,093	\$1,795,078	\$1,813,029
GS-14.....	716,123	738,271	745,654
GS-13.....	4,481,666	4,620,274	4,666,477
GS-12.....	1,754,040	1,808,289	1,826,372
GS-11.....	184,661	190,372	192,276
GS-10.....	0	41,635	42,051
GS-9.....	240,434	247,870	250,349
GS-8.....	103,202	106,394	107,458
GS-7.....	259,605	267,634	270,310
GS-6.....	105,794	109,066	110,157
GS-5.....	48,139	49,628	50,124
GS-4.....	0	0	0
Subtotal.....	\$9,732,757	\$9,974,511	\$10,074,256
Total full-time equivalent employment, end of year.....	177	177	177
Full-time equivalent (FTE) usage.....	177	174	177
Average ES level.....	2	2	2
Average ES salary.....	\$101,708	\$104,099	\$104,099
Average GS grade.....	\$54,987	\$56,353	\$56,917
Average GS salary.....	12.9	12.9	12.9

ADMINISTRATION ON AGING
Title III - B Support Services and Senior Centers

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Total	\$ 306,711,000	189,393,779	294,787,000
Alaska	1,544,752	946,785	1,473,935
Alabama	4,954,849	3,060,086	4,765,070
Arkansas	3,398,154	2,104,900	3,269,339
American Samoa	471,489	304,614	459,649
Arizona	3,932,267	2,388,528	3,719,178
California	28,480,629	17,548,628	27,372,315
Colorado	3,035,331	1,860,910	2,912,209
Connecticut	4,287,837	2,653,018	4,121,725
Dist. of Columbia	1,544,752	946,785	1,473,935
Delaware	1,544,752	946,785	1,473,935
Florida	19,277,754	11,780,959	18,444,717
Georgia	6,073,237	3,737,826	5,835,673
Guam	777,975	473,393	736,968
Hawaii	1,570,741	975,838	1,514,922
Iowa	4,144,606	2,574,096	3,993,952
Idaho	1,557,242	970,830	1,506,307
Illinois	14,086,553	8,744,183	13,578,132
Indiana	6,628,469	4,095,766	6,374,550
Kansas	3,339,629	2,070,396	3,213,730
Kentucky	4,543,703	2,813,931	4,375,729
Louisiana	4,601,318	2,850,075	4,433,105
Massachusetts	7,971,539	4,950,225	7,682,985
Maryland	4,826,555	2,966,685	4,627,815
Maine	1,635,722	1,009,820	1,568,486
Michigan	10,554,970	6,520,151	10,149,807
Minnesota	5,219,486	3,231,304	5,023,138
Missouri	6,909,409	4,283,356	6,655,038
Mississippi	3,172,041	1,966,297	3,053,771
Montana	1,544,752	959,646	1,487,657
North Carolina	7,232,858	4,437,875	6,938,592
North Dakota	1,544,752	946,785	1,473,935
Nebraska	2,236,686	1,387,381	2,151,377
New Hampshire	1,567,043	973,959	1,511,065
New Jersey	9,954,588	6,161,114	9,577,623
New Mexico	1,575,638	966,849	1,535,909
Notern Marianas	202,892	120,745	185,794
Nevada	1,588,280	985,219	1,531,731
New York	23,579,441	14,666,898	22,748,998
Ohio	13,403,131	8,286,578	12,895,322

ADMINISTRATION ON AGING
Title III - B Support Services and Senior Centers

States	FY 1995	FY 1996	FY 1997
	Actual	Actual*	Estimates
Oklahoma	4,137,463	2,566,139	3,988,018
Oregon	3,519,530	2,166,006	3,378,714
Pennsylvania	17,394,343	10,778,595	16,753,072
Puerto Rico	2,943,953	1,800,430	2,815,894
Palau	139,689	104,767	69,845
Rhode Island	1,593,597	986,608	1,531,387
South Carolina	3,574,732	2,190,350	3,424,890
South Dakota	1,544,752	954,299	1,478,534
Tennessee	5,841,702	3,604,381	5,615,869
Texas	15,942,288	9,827,534	15,346,243
Utah	1,594,427	986,102	1,538,931
Virginia	6,100,571	3,745,958	5,850,914
Virgin Islands	777,975	473,393	736,968
Vermont	1,544,752	946,785	1,473,935
Washington	5,108,450	3,138,042	4,900,881
Wisconsin	6,193,114	3,834,051	5,962,128
West Virginia	2,699,088	1,674,334	2,598,726
Wyoming	1,544,752	946,785	1,473,935

*Based on funding levels through the ninth continuing resolution

ADMINISTRATION ON AGING
Title III - C-1 Congregate Nutrition Services

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Total	375,509,000	356,944,000	357,019,000
Alaska	1,891,254	1,784,720	1,785,095
Alabama	6,065,871	5,763,262	5,765,219
Arkansas	4,172,078	3,970,620	3,971,876
American Samoa	605,360	590,631	590,637
Arizona	4,761,936	4,472,642	4,433,138
California	34,780,266	33,015,536	33,027,245
Colorado	3,697,868	3,493,821	3,495,166
Connecticut	5,260,088	5,003,783	5,005,377
Dist. of Columbia	1,891,254	1,818,094	1,818,360
Delaware	1,891,254	1,820,059	1,820,376
Florida	23,424,133	22,112,266	22,120,867
Georgia	7,413,786	7,028,142	7,030,695
Guam	952,482	892,360	892,548
Hawaii	1,941,687	1,854,493	1,854,998
Iowa	5,095,340	4,858,839	4,860,331
Idaho	1,931,235	1,850,790	1,851,256
Illinois	17,294,715	16,497,319	16,502,500
Indiana	8,116,768	7,716,288	7,718,872
Kansas	4,102,999	3,907,061	3,908,275
Kentucky	5,572,879	5,304,235	5,305,969
Louisiana	5,643,028	5,371,481	5,373,250
Massachusetts	9,793,315	9,342,292	9,345,165
Maryland	5,892,781	5,581,153	5,583,137
Maine	2,008,898	1,905,744	1,906,343
Michigan	12,919,097	12,282,233	12,286,367
Minnesota	6,401,206	6,092,205	6,094,179
Missouri	8,478,850	8,078,395	8,080,974
Mississippi	3,896,104	3,709,384	3,710,554
Montana	1,911,376	1,839,378	1,839,779
North Carolina	8,811,429	8,336,875	8,340,013
North Dakota	1,891,254	1,825,918	1,826,239
Nebraska	2,751,692	2,619,773	2,620,563
New Hampshire	1,940,920	1,856,438	1,856,908
New Jersey	12,202,429	11,615,963	11,619,727
New Mexico	1,926,265	1,819,223	1,853,789
Northern Marianas	252,837	238,631	238,635
Nevada	1,953,086	1,857,836	1,858,437
New York	28,986,352	27,691,206	27,699,618
Ohio	16,411,946	15,612,935	15,618,143

ADMINISTRATION ON AGING
Title III - C-1 Congregate Nutrition Services

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Oklahoma	5,079,555	4,838,961	4,840,517
Oregon	4,300,503	4,074,930	4,076,378
Pennsylvania	21,329,645	20,323,542	20,330,100
Puerto Rico	3,584,529	3,381,536	3,382,819
Palau	171,012	128,259	85,506
Rhode Island	1,966,444	1,873,471	1,873,988
South Carolina	4,355,109	4,114,515	4,116,067
South Dakota	1,902,822	1,835,032	1,835,393
Tennessee	7,145,891	6,785,915	6,788,253
Texas	19,462,461	18,476,182	18,482,926
Utah	1,958,799	1,859,997	1,868,066
Virginia	7,438,926	7,041,506	7,044,092
Virgin Islands	952,482	892,360	892,548
Vermont	1,891,254	1,807,861	1,808,108
Washington	6,231,296	5,899,157	5,901,317
Wisconsin	7,592,928	7,227,087	7,229,451
West Virginia	3,317,972	3,159,821	3,160,800
Wyoming	1,891,254	1,791,844	1,792,034

*Based on funding levels through the ninth continuing resolution

ADMINISTRATION ON AGING
Title III - C-2 Home-Delivered Nutrition Services

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Total	94,065,000	89,362,000	94,191,000
Alaska	473,758	446,810	470,955
Alabama	1,519,120	1,444,754	1,523,265
Arkansas	1,036,395	985,923	1,036,335
American Samoa	130,948	127,257	127,530
Arizona	1,149,398	1,079,942	1,143,643
California	8,773,912	8,331,668	8,801,767
Colorado	938,522	891,808	945,775
Connecticut	1,310,070	1,244,087	1,308,077
Dist. of Columbia	473,758	446,810	470,955
Delaware	473,758	446,810	470,955
Florida	5,991,824	5,657,976	6,003,180
Georgia	1,872,061	1,779,441	1,881,904
Guam	238,596	223,405	235,478
Hawaii	473,758	452,259	472,543
Iowa	1,260,923	1,201,740	1,261,605
Idaho	473,758	447,592	470,955
Illinois	4,297,464	4,093,908	4,301,880
Indiana	2,031,584	1,930,995	2,034,679
Kansas	1,017,206	967,791	1,016,509
Kentucky	1,388,485	1,322,945	1,392,542
Louisiana	1,406,301	1,340,985	1,411,981
Massachusetts	2,429,106	2,314,064	2,430,157
Maryland	1,487,441	1,408,820	1,488,458
Maine	498,328	472,482	496,496
Michigan	3,237,831	3,076,116	3,242,036
Minnesota	1,595,204	1,517,691	1,596,916
Missouri	2,109,488	2,008,622	2,112,117
Mississippi	966,614	920,625	967,593
Montana	473,758	446,810	470,955
North Carolina	2,237,561	2,122,061	2,248,004
North Dakota	473,758	446,810	470,955
Nebraska	679,407	646,322	678,039
New Hampshire	473,758	449,046	470,955
New Jersey	3,045,905	2,894,783	3,045,852
New Mexico	549,479	523,765	559,785
Notern Marianas	62,224	55,851	58,869
Nevada	483,020	462,609	486,745
New York	7,176,614	6,842,208	7,179,840
Ohio	4,108,573	3,905,590	4,114,631

ADMINISTRATION ON AGING
Title III - C-2 Home-Delivered Nutrition Services

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Oklahoma	1,261,965	1,204,029	1,266,469
Oregon	1,082,499	1,027,857	1,085,959
Pennsylvania	5,318,335	5,061,223	5,324,412
Puerto Rico	910,323	860,502	911,997
Palau	42,858	32,144	21,429
Rhode Island	481,575	457,466	478,218
South Carolina	1,105,644	1,047,469	1,109,754
South Dakota	473,758	446,810	470,955
Tennessee	1,793,868	1,705,059	1,798,929
Texas	4,912,938	4,680,554	4,951,251
Utah	500,067	477,033	503,008
Virginia	1,884,183	1,785,772	1,889,552
Virgin Islands	238,596	223,405	235,478
Vermont	473,758	446,810	470,955
Washington	1,576,204	1,494,866	1,581,584
Wisconsin	1,893,807	1,802,639	1,897,505
West Virginia	821,196	782,371	821,672
Wyoming	473,758	446,810	470,955

*Based on funding levels through the ninth continuing resolution

ADMINISTRATION ON AGING
Title III - D In-Home Services for Frail Elderly

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Total	\$ 9,263,000	4,112,772	9,263,000
Alaska	46,652	20,564	46,315
Alabama	148,742	66,482	149,754
Arkansas	96,361	42,689	96,157
American Samoa	6,127	2,571	5,789
Arizona	142,644	64,335	143,784
California	895,856	398,049	896,674
Colorado	99,657	45,699	102,939
Connecticut	123,621	54,186	122,056
Dist. of Columbia	46,652	20,564	46,315
Delaware	46,652	20,564	46,315
Florida	661,960	292,314	658,451
Georgia	192,351	86,763	195,440
Guam	23,495	10,282	23,158
Hawaii	46,652	20,564	46,315
Iowa	114,314	50,694	114,189
Idaho	46,652	20,564	46,315
Illinois	399,461	176,108	396,692
Indiana	198,036	87,799	197,771
Kansas	93,392	41,253	92,926
Kentucky	131,513	58,935	132,752
Louisiana	133,424	60,118	135,418
Massachusetts	223,085	98,307	221,441
Maryland	152,462	67,436	151,903
Maine	46,652	20,564	46,315
Michigan	318,082	140,499	316,481
Minnesota	151,320	67,086	151,116
Missouri	197,897	87,638	197,409
Mississippi	89,177	39,773	89,587
Montana	46,652	20,564	46,315
North Carolina	237,554	106,647	240,228
North Dakota	46,652	20,564	46,315
Nebraska	60,779	26,859	60,498
New Hampshire	46,652	20,564	46,315
New Jersey	291,397	127,923	288,152
New Mexico	48,566	21,829	50,084
Northern Marianas	6,127	2,571	5,789
Nevada	46,652	20,564	46,315
New York	651,283	285,901	644,008
Ohio	400,724	177,012	398,730

ADMINISTRATION ON AGING
Title III - D In-Home Services for Frail Elderly

States	FY 1995	FY 1996	FY 1997
	Actual	Actual*	Estimates
Oklahoma	117,425	52,874	119,100
Oregon	109,532	49,200	110,825
Pennsylvania	505,636	222,864	502,014
Puerto Rico	97,609	43,606	98,224
Palau	4,229	1,431	2,115
Rhode Island	46,652	20,564	46,315
South Carolina	117,318	52,743	118,804
South Dakota	46,652	20,564	46,315
Tennessee	178,052	79,488	179,050
Texas	504,342	229,222	516,335
Utah	46,467	20,483	46,315
Virginia	197,103	87,881	197,954
Virgin Islands	23,495	10,282	23,158
Vermont	46,652	20,564	46,315
Washington	164,036	73,431	165,408
Wisconsin	180,652	80,333	180,950
West Virginia	74,569	33,280	74,964
Wyoming	46,652	20,564	46,315

*Based on funding levels through the ninth continuing resolution

ADMINISTRATION ON AGING
Title III - F Preventive Health Services

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Total	\$ 16,982,000	0	16,982,000
Alaska	85,529		84,910
Alabama	272,691		274,547
Arkansas	176,661		176,287
American Samoa	11,233		10,614
Arizona	261,512		263,602
California	1,642,376		1,643,888
Colorado	182,703		188,720
Connecticut	226,636		223,767
Dist. of Columbia	85,529		84,910
Delaware	85,529		84,910
Florida	1,213,581		1,207,150
Georgia	352,641		358,303
Guam	43,074		42,455
Hawaii	85,529		84,910
Iowa	209,574		209,344
Idaho	85,529		84,910
Illinois	732,338		727,262
Indiana	363,063		362,577
Kansas	171,217		170,362
Kentucky	241,105		243,376
Louisiana	244,609		248,264
Massachusetts	408,985		405,971
Maryland	279,511		278,486
Maine	85,529		84,910
Michigan	583,145		580,209
Minnesota	277,418		277,043
Missouri	362,808		361,914
Mississippi	163,490		164,242
Montana	85,529		84,910
North Carolina	435,512		440,413
North Dakota	85,529		84,910
Nebraska	111,428		110,912
New Hampshire	85,529		84,910
New Jersey	534,222		528,274
New Mexico	89,037		91,820
Notern Marianas	11,233		10,614
Nevada	85,529		84,910
New York	1,194,007		1,180,670
Ohio	734,654		730,998

ADMINISTRATION ON AGING
Title III - F Preventive Health Services

Oklahoma	215,277	218,348
Oregon	200,807	203,177
Pennsylvania	926,991	920,351
Puerto Rico	178,949	180,076
Palau	7,734	3,867
Rhode Island	85,529	84,910
South Carolina	215,081	217,805
South Dakota	85,529	84,910
Tennessee	326,425	328,256
Texas	924,618	946,605
Utah	85,190	84,910
Virginia	361,353	362,912
Virgin Islands	43,074	42,455
Vermont	85,529	84,910
Washington	300,731	303,245
Wisconsin	331,192	331,738
West Virginia	136,708	137,432
Wyoming	85,529	84,910

*Based on funding levels through the ninth continuing resolution

ADMINISTRATION ON AGING
Ombudsman Services

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Total	\$ 4,449,000	0	4,449,000
Alaska	22,407		22,245
Alabama	71,440		71,917
Arkansas	46,282		46,178
American Samoa	2,943		2,781
Arizona	68,509		69,050
California	430,277		430,616
Colorado	47,864		49,435
Connecticut	59,374		58,616
Dist of Columbia	22,407		22,245
Delaware	22,407		22,245
Florida	317,937		316,212
Georgia	92,386		93,857
Guam	11,284		11,123
Hawaii	22,407		22,245
Iowa	54,904		54,838
Idaho	22,407		22,245
Illinois	191,860		190,506
Indiana	95,116		94,977
Kansas	44,855		44,626
Kentucky	63,165		63,752
Louisiana	64,083		65,033
Massachusetts	107,147		106,344
Maryland	73,227		72,949
Maine	22,407		22,245
Michigan	152,773		151,986
Minnesota	72,678		72,571
Missouri	95,049		94,803
Mississippi	42,831		43,023
Montana	22,407		22,245
North Carolina	114,096		115,366
North Dakota	22,407		22,245
Nebraska	29,192		29,053
New Hampshire	22,407		22,245
New Jersey	139,957		138,381
New Mexico	23,327		24,052
North Marianas	2,943		2,781
Nevada	22,407		22,245
New York	312,809		309,276
Ohio	192,466		191,485

ADMINISTRATION ON AGING
Ombudsman Services

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Oklahoma	56,398		57,196
Oregon	52,607		53,222
Pennsylvania	242,856		241,086
Puerto Rico	46,881		47,171
Palau	2,050		1,538
Rhode Island	22,407		22,245
South Carolina	56,347		57,054
South Dakota	22,407		22,245
Tennessee	85,517		85,986
Texas	242,234		247,963
Utah	22,319		22,245
Virginia	94,668		95,065
Virgin Islands	11,284		11,123
Vermont	22,407		22,245
Washington	78,786		79,435
Wisconsin	86,766		86,899
West Virginia	35,815		36,000
Wyoming	22,407		22,245

*Based on funding levels through the ninth continuing resolution

ADMINISTRATION ON AGING
Title VII Prevention of Elder Abuse

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Total	4,732,000	0	4,732,000
Alaska	23,832		23,660
Alabama	75,984		76,492
Arkansas	49,225		49,116
American Samoa	3,129		2,958
Arizona	72,868		73,442
California	457,645		458,006
Colorado	50,909		52,579
Connecticut	63,151		62,344
Dist. of Columbia	23,832		23,660
Delaware	23,832		23,660
Florida	338,161		336,326
Georgia	98,262		99,827
Guam	12,002		11,830
Hawaii	23,832		23,660
Iowa	58,396		58,326
Idaho	23,832		23,660
Illinois	204,064		202,624
Indiana	101,166		101,018
Kansas	47,708		47,465
Kentucky	67,183		67,807
Louisiana	68,159		69,169
Massachusetts	113,962		113,108
Maryland	77,884		77,589
Maine	23,832		23,660
Michigan	162,491		161,653
Minnesota	77,301		77,187
Missouri	101,095		100,833
Mississippi	45,555		45,760
Montana	23,832		23,660
North Carolina	121,354		122,704
North Dakota	23,832		23,660
Nebraska	31,049		30,901
New Hampshire	23,832		23,660
New Jersey	148,859		147,183
New Mexico	24,810		25,582
Notern Marianas	3,129		2,958
Nevada	23,832		23,660
New York	332,706		328,948
Ohio	204,709		203,664

ADMINISTRATION ON AGING
Title VII Prevention of Elder Abuse

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Oklahoma	59,986		60,834
Oregon	55,953		56,607
Pennsylvania	258,303		256,420
Puerto Rico	49,863		50,171
Palau	2,198		1,649
Rhode Island	23,832		23,660
South Carolina	59,931		60,683
South Dakota	23,832		23,660
Tennessee	90,957		91,456
Texas	257,642		263,735
Utah	23,738		23,660
Virginia	100,689		101,111
Virgin Islands	12,002		11,830
Vermont	23,832		23,660
Washington	83,797		84,487
Wisconsin	92,285		92,426
West Virginia	38,092		38,290
Wyoming	23,832		23,660

*Based on funding levels through the ninth continuing resolution

ADMINISTRATION ON AGING
Title VII Outreach and Insurance Counseling

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Total	\$ 1,976,000	0	1,976,000
Alaska	9,952		9,880
Alabama	31,730		31,942
Arkansas	20,556		20,510
American Samoa	1,307		1,235
Arizona	30,428		30,668
California	191,104		191,256
Colorado	21,259		21,956
Connecticut	26,371		26,034
Dist. of Columbia	9,952		9,880
Delaware	9,952		9,880
Florida	141,210		140,444
Georgia	41,033		41,686
Guam	5,012		4,940
Hawaii	9,952		9,880
Iowa	24,385		24,356
Idaho	9,952		9,880
Illinois	85,214		84,612
Indiana	42,245		42,184
Kansas	19,922		19,821
Kentucky	28,054		28,315
Louisiana	28,462		28,884
Massachusetts	47,589		47,232
Maryland	32,523		32,400
Maine	9,952		9,880
Michigan	67,854		67,504
Minnesota	32,280		32,232
Missouri	42,216		42,106
Mississippi	19,023		19,109
Montana	9,952		9,880
North Carolina	50,675		51,239
North Dakota	9,952		9,880
Nebraska	12,966		12,904
New Hampshire	9,952		9,880
New Jersey	62,161		61,461
New Mexico	10,361		10,683
Northern Marianas	1,307		1,235
Nevada	9,952		9,880
New York	138,933		137,364
Ohio	85,483		85,047

ADMINISTRATION ON AGING
Title VII Outreach and Insurance Counseling

States	FY 1995 Actual	FY 1996 Actual*	FY 1997 Estimates
Oklahoma	25,049		25,403
Oregon	23,365		23,638
Pennsylvania	107,863		107,077
Puerto Rico	20,822		20,951
Palau	908		681
Rhode Island	9,952		9,880
South Carolina	25,026		25,340
South Dakota	9,952		9,880
Tennessee	37,982		38,190
Texas	107,587		110,131
Utah	9,913		9,880
Virginia	42,046		42,222
Virgin Islands	5,012		4,940
Vermont	9,952		9,880
Washington	34,992		35,281
Wisconsin	38,537		38,596
West Virginia	15,907		15,989
Wyoming	9,952		9,880

*Based on funding levels through the ninth continuing resolution

Fiscal year 1997 Moyer Material

Health Tables:	Page
Acquired Immunodeficiency Syndrome	992
Alzheimer's Disease	994
Bone Marrow	995
Cancer	996
Cystic Fibrosis	997
Diabetes	998
Homeless	999
Immunization	1000
Infant Mortality	1001
Long-Term Care	1002
Mental Retardation	1003
Minority Health and Assistance	1004
Pediatric AIDS	1006
Rural Health	1007
Sexually Transmitted Diseases	1008
Stroke	1009
Substance Abuse	1010
Non-Health Tables:	
Aging	1012
Child Care	1014
Family Planning	1015
Special Tables: Impact of Federal Abortion Funding Limita- tion	1016
Health Related Tables:	
National and Federal Expenditures	1026
Congressional Action on Budget for NIH	1028
Women's Health	1030
Cross-cutting Tables:	
T-1—Expired Legislative Authority	1032
T-2—Employment	1037
T-3—Entertainment Fund	1038
T-4—New Programs	1039
T-5—Unobligated Carryover Balances	1040
T-6—Legislative Programs	1045
T-7—Budget Authority	1047
T-8—Expenditures	1048
T-9—Travel	1049
T-10—Program Support and Program Management	1050
T-11—Entitlement vs. Discretionary	1051
T-12—Administrative Expenses	1052

ACQUIRED IMMUNODEFICIENCY SYNDROME

	Budget Authority (Dollars in Thousands)							
	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Health Resources & Services Administration	\$112,467	\$265,802	\$318,812	\$390,341	\$607,796	\$661,185	\$792,526	\$835,885
Centers for Disease Control & Prevention	442,812	496,951	479,820	498,253	543,253	589,831	584,533	618,081
National Institutes of Health								
NCI	148,289	160,869	165,869	173,029	213,017	217,735	225,790	220,539
NHLBI	42,056	48,406	46,206	48,058	54,977	55,485	57,925	58,115
NIDR	4,862	6,214	8,154	8,375	12,185	11,733	12,309	12,318
NIDDK	5,306	8,290	7,172	6,446	10,437	10,752	11,735	11,948
NINDS	18,158	18,851	17,582	18,418	22,113	22,741	23,807	23,950
NIAID	394,088	430,840	448,840	458,888	542,912	557,766	596,018	624,368
NIGMS	14,814	16,588	18,100	18,850	23,943	24,884	26,135	27,050
NICHD	26,749	32,609	34,729	38,807	56,426	58,867	60,713	60,205
NEI	5,533	5,680	5,902	6,283	8,381	8,606	9,125	9,135
NIHRS	4,258	4,514	4,229	4,272	5,608	5,745	6,051	6,028
NIA	859	985	1,072	1,153	1,886	1,715	1,785	1,824
NIAMS	1,238	1,633	1,694	1,780	1,501	3,879	4,039	3,972
NIDCO	-	495	483	618	849	1,552	1,650	1,726
NIHMH	63,331	72,720	78,140	78,433	87,182	89,351	93,556	93,056
NIDA	92,635	122,688	125,269	127,047	143,376	147,347	153,331	154,311
NIAAA	7,980	7,998	7,990	8,823	9,457	9,741	10,135	10,334
NCRR	46,147	47,429	50,051	50,881	61,383	64,630	68,370	68,255
NCHGR	-	-	-	-	637	993	1,000	2,087
NINR	987	2,545	2,710	2,966	4,229	4,577	4,896	5,015
FIC	4,898	5,351	5,593	5,884	8,852	9,108	9,694	9,757
NLM	483	519	1,057	1,101	2,782	2,894	3,162	3,311
OD	10,284	11,737	13,889	14,581	24,538	24,394	26,598	24,800
B&F	12,880	4,966	7,000	3,753	---	---	---	---
Total, NIH	964,455	1,064,825	1,047,440	1,075,634	1,296,471	1,333,875	1,407,824	1,431,908
Health Services Administration	49,865	30,118	28,025	25,655	27,320	24,085	14,300	11,939
Agency for Health Care Policy & Research	8,470	10,237	10,135	9,824	10,624	9,084	6,834	4,755
Office of the Assistant Secretary for Health	7,676	5,334	4,794	5,330	5,283	---	---	---

ACQUIRED IMMUNODEFICIENCY SYNDROME

Budget Authority
(Dollars in Thousands)

	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Office of the Secretary	--	--	--	--	--	4,071	2,771	2,771
Health Care Financing								
Administration	780,000	1,050,000	1,360,000	1,675,000	1,990,000	2,240,000	2,490,000	2,750,000
Social Security Administration 1/	249,000	360,000	501,000	670,000	840,000	940,000	1,080,000	1,245,000
Office of Civil Rights	2,700	2,700	2,700	2,800	2,800	1,975	1,752	1,961
Subtotal, L/HHS Agencies	1,557,445	3,278,067	3,748,326	4,352,037	5,323,327	5,804,116	6,380,340	6,902,100
Food & Drug Administration	57,428	63,395	72,302	72,628	72,399	72,745	72,745	72,745
Indian Health Service	2,670	1,803	3,170	3,303	3,556	3,637	3,660	3,847
Total, HHS	2,617,543	3,291,265	3,823,798	4,427,968	5,399,282	5,880,498	6,456,745	6,978,692
Veterans Affairs Department	220,000	258,000	279,000	325,000	312,000	317,000	337,000	347,000
Defense Department	125,000	127,000	129,000	159,000	129,000	112,000	103,000	85,000
Agency for International Development	71,000	78,000	94,000	117,000	115,000	120,000	111,000	97,000
Justice/Bureau of Prisons	5,000	5,000	5,000	5,000	6,000	6,000	6,000	7,000
State Department	1,000	1,000	1,000	1,000	1,000	1,000	0	0
Labor Department	1,000	1,000	1,000	1,000	1,000	1,000	1,000	2,000
Housing & Urban Development	--	--	48,000	100,000	158,000	171,000	171,000	171,000
Office of Personnel Management FEHB	21,000	34,000	58,000	89,000	108,000	212,000	226,000	241,000
Total, HIV/AIDS	3,061,543	3,795,265	4,438,798	5,233,968	6,227,282	6,820,498	7,411,745	7,928,692

ALZHEIMER'S DISEASE

Budget Authority
(Dollars in Thousands)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Health Resources & Services Administration	\$4,959	\$4,959	\$4,959	\$3,993 1/	2/
Centers for Disease Control and Prevention	33	63	40	40	40
National Institutes of Health					
NCI	593	564	306	306	306
NHLBI	1,954	2,076	963	1,000	1,025
NIDR	---	---	---	---	---
NIDDK	2,100	2,200	953	990	1,000
NINDS	42,266	44,460	45,871	47,717	48,563
NIAID	2,364	1,585	0	0	0
NICHD	266	392	425	500	500
NEI	1,444	1,335	957	1,004	1,020
NIEHS	97	356	822	855	874
NIA	202,744	212,797	214,962	223,000	227,000
NIAMS	1,625	1,434	1,156	1,230	1,250
NIDCD	1,438	1,585	1,311	1,389	1,418
NIMH	24,185	24,390	24,308	25,701	26,128
NIAAA	823	554	231	200	200
NCRR	1,911	1,204	1,276	1,415	1,415
NINR	3,369	3,122	3,145	3,350	3,400
FIC	60	50	55	60	60
National Institutes of Health	287,239	298,104	296,741	308,717	314,159
Substance Abuse & Mental Health Services Administration	60	30	---	---	---
Agency for Health Care Policy & Research	628	645	250	500	250
Subtotal, L/HHS	292,919	303,801	301,990	313,250	314,449
Health Care Financing Administration	1,400	1,500	1,700	1,900	2,100
Administration on Aging	300	350	300	300	300
Total Alzheimer's Disease	294,619	305,651	303,990	315,450	316,849

1/ Estimate - Alzheimer's program included in cluster for Programs for Special Populations

2/ No specific amount - Alzheimer's program included in cluster Programs for Special Populations.

BONE MARROW

Budget Authority
(Dollars in Thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
Health Resources & Services Administration	\$16,234	\$11,171	\$15,360	\$15,332	\$15,332
National Institutes of Health					
NCI	49,617	49,647	58,403	61,199	61,809
NHLBI	28,243	34,554	39,416	40,700	41,400
NIDR	788	1,492	1,298	1,381	1,411
NIDDK	7,269	7,600	7,800	8,100	8,200
NINDS	706	1,039	846	892	912
NIAID	6,686	6,243	5,313	5,526	5,636
NICHD	---	---	750	800	800
NIEHS	2,649	2,859	3,327	3,460	3,511
NIA	---	481	734	750	760
NIAMS	953	1,285	927	970	1,000
NIMH	---	774	2,655	2,791	2,799
NINR	---	---	310	330	340
NCRR	786	960	1,018	1,120	1,120
Total Bone Marrow	113,931	118,105	138,157	143,351	145,030

CANCER

Budget Authority
(Dollars in Thousands)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Centers for Disease Control and Prevention	\$82,053	\$113,108	\$136,506	\$150,304	\$149,829
<u>National Institutes of Health</u>					
NCI	1,978,340	2,078,948	2,130,858	2,251,064	2,280,931
NHLBI	33,988	35,420	33,956	35,000	35,800
NIDR	8,890	7,574	8,956	9,551	9,672
NIDDK	21,600	25,600	34,837	36,100	36,530
NINDS	12,285	13,798	11,310	11,749	11,958
NIAD	30,900	28,747	35,707	37,135	37,878
NIGMS	8,785	11,715	17,317	21,480	21,793
NICHD	4,601	7,725	8,227	8,800	8,700
NEI	9,807	9,416	9,105	9,553	9,706
NIHHS	79,788	73,001	81,581	88,104	90,657
NIA	6,639	9,199	9,385	9,820	9,760
NIDCD	1,010	—	1,259	1,340	1,353
NIAMS	3,119	4,849	5,591	5,910	6,045
NIMH	4,134	4,022	4,805	4,861	4,923
NIDA	950	1,198	460	480	500
NIAAA	1,397	1,399	1,961	2,150	2,150
NCRR	18,902	19,361	20,553	22,796	22,796
NINR	3,740	4,023	4,178	4,450	4,500
NCHGR	—	11,475	14,538	16,483	17,042
FIC	361	398	310	325	325
National Institutes of Health	2,225,214	2,345,888	2,434,304	2,578,781	2,612,819
Agency for Health Care Policy and Research	4,220	4,358	3,647	1,307	3,469
Subtotal, LHHS	2,311,487	2,483,133	2,674,457	2,728,392	2,708,117
Health Care Financing Administration	13,395,000	15,095,000	17,125,000	16,975,000	21,035,000
Total Cancer	15,708,487	17,558,133	19,899,457	21,703,392	23,801,117

CYSTIC FIBROSIS

Budget Authority
(Dollars in Thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
<u>National Institutes of Health</u>					
NCI	\$325	\$168	\$143	\$146	\$147
NHLBI	20,537	17,140	15,969	16,500	16,800
NIDR	1,995	1,778	1,434	1,524	1,536
NIDDK	21,500	21,889	21,670	22,600	22,900
NIAID	15,395	16,532	16,777	17,448	17,979
NICHD	484	359	0	0	0
NEI	372	429	404	424	431
NIEHS	0	505	450	468	473
NIAMS	224	230	180	190	195
NCRR	1,517	861	879	953	967
NCHGR	621	364	714	754	780
NINR	309	25	25	25	30
National Institutes of Health	63,279	60,280	58,645	61,032	62,238
Health Care Financing Administration	<u>40</u>	<u>40</u>	<u>50</u>	<u>50</u>	<u>60</u>
Total Cystic Fibrosis	63,319	60,320	58,695	61,082	62,298

DIABETES AND RELATED RESEARCH *

Budget Authority
(Dollars in Thousands)

	FY1993	FY1994	FY1995	FY1996	FY1997
Centers for Disease Control and Prevention	\$10,000	\$18,410	\$19,865	\$23,615	\$24,016
National Institutes of Health					
NCI	1,204	1,279	1,070	1,120	1,130
NHLBI	20,716	19,779	20,360	21,100	21,500
NIDR	2,258	2,505	2,577	2,723	2,745
NIDDK	187,100	191,409	193,597	202,700	205,500
NINDS	5,859	5,717	4,535	4,769	4,866
NIAD	3,764	4,898	4,737	4,926	5,025
NIGMS	1,629	1,704	1,762	1,815	1,851
NICHD	12,621	12,329	12,631	13,200	13,400
NEI	22,150	22,605	22,001	23,083	23,452
NIEHS	643	415	318	331	341
NIA	5,389	6,666	6,652	6,820	6,920
NIMH	1,754	2,036	1,230	1,303	1,331
NIAAA	---	329	302	305	305
NCRR	19,025	18,577	19,501	21,346	20,723
NCHGR	---	2,181	2,603	2,750	2,845
NINR	1,397	1,130	1,276	1,350	1,400
FIC	140	56	0	0	0
National Institutes of Health	285,849	293,815	295,142	309,841	313,334
Agency for Health Care Policy & Research	1,105	1,277	0	0	0
Subtotal L/HHS	296,754	313,302	315,007	333,256	337,350
Health Care Financing Administration	5,200	5,900	6,500	7,200	7,800
Subtotal L/HHS	301,954	319,202	321,507	340,456	345,150
Indian Health Service	6,722	6,722	7,701	7,701	8,000
Total Diabetes	308,676	325,924	329,208	348,157	353,150

* This table excludes AREA awards.

HOMELESS PROGRAMS

Budget Authority
(Dollars in Thousands)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Health Resources & Services Administration /1	\$57,014	\$63,011	\$64,995	\$65,000	\$65,000
Substance Abuse & Mental Health Services Administration /2	77,954	53,770	53,968	39,206	52,723
National Institutes of Health					
NIMH Research Grants	\$9,927	\$10,514	\$11,164	\$11,818	\$12,019
NIDA Research Grants	6,000	6,079	6,256	6,500	6,600
NIAAA Research Grants	256	685	629	650	650
Nursing Research Grants	—	171	190	200	210
Subtotal, National Institutes of Health	\$16,183	\$17,449	\$18,239	\$19,168	\$19,479
Administration for Children and Families /3	88,204	90,927	95,695	57,148	68,572
TOTAL HHS	\$239,355	\$225,157	\$232,897	\$180,522	\$205,774
Housing and Urban Development /4	590,700	822,700	822,700	1,120,000	1,120,000
Federal Emergency Management Administration	129,000	130,000	130,000	46,000	100,000
Interagency Council on the Homeless	900	—	—	—	—
Department of Labor	12,500	12,500	5,000	—	—
Department of Education	34,400	35,100	38,300	23,000	29,000
Department of Veterans Affairs	46,900	57,900	67,400	67,400	67,400
Department of Agriculture	32,000	40,000	40,000	40,000	40,000
TOTAL HOMELESS	\$1,085,755	\$1,323,357	\$1,336,297	\$1,476,922	\$1,562,174

/1 Excludes \$450 thousand in FY 1994 and FY 1995 provided to DOJ for a liability insurance pool for all Federal health grantees.

/2 After FY 1993, SAMHSA's Community Support Program no longer supports the homeless.

/3 In FY 1996 and FY 1997, ACF's Family Support Centers are not included because the Administration proposes to combine them with non-homeless ACF programs.

/4 FY 1995 excludes \$297 million in rescinded funds. These funds are included in FY 1996 and FY 1997.

IMMUNIZATION - All Ages

Budget Authority
(Dollars in Thousands)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Health Resources & Services Administration	\$1,600	\$1,600	\$1,600	\$1,600	\$1,600
Centers for Disease Control & Prevention	341,081	509,283	728,734	877,851	1,011,845
National Institutes of Health					
NICI	60,391	64,323	72,558	76,028	78,918
NHLBI	2,840	1,131	1,423	1,470	1,500
NIOR	3,875	5,742	6,021	6,470	6,587
NIDDK	1,800	1,900	1,950	2,030	2,050
NINDS	1,115	1,079	731	739	741
NIAID	145,901	181,619	183,808	196,971	206,975
NICHD	8,899	6,937	6,102	6,400	6,600
NIEHS	729	145	0	0	0
NEI	1,484	1,183	628	659	670
NIA	530	1,186	1,466	1,500	1,520
NIAMS	0	0	0	0	0
NIDCD	78	633	0	0	0
NIMH	3,157	0	0	0	0
NIDA	6,909	6,400	0	0	0
NCRR	12,992	15,672	18,308	17,992	17,992
NINR	0	0	894	1,050	1,070
NCHGR	0	0	0	0	0
FIC	4,046	6,816	0	0	0
NIH TOTAL	253,344	294,726	291,989	311,307	322,623
Agency for Health Care Policy & Research	1,065	1,286	424	0	0
Office of the Assistant Secretary for Health	2,737	2,448	0	0	0
Health Care Financing Admin.	270,000	300,000	280,000	195,000	220,000
Subtotal, L/HHS Agencies	869,827	1,209,343	1,282,747	1,385,758	1,556,088
Food and Drug Administration	26,988	37,000	37,277	37,277	37,277
Indian Health Service	1,287	1,348	1,328	1,328	1,352
Total Immunization-All Ages	\$898,112	\$1,247,691	\$1,321,352	\$1,424,363	\$1,594,697

INFANT MORTALITY

Budget Authority
(Dollars in Thousands)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Health Resources and Services Administration	\$773,500	\$828,951	\$875,348	\$850,785	\$861,956
Centers for Disease Control and Prevention	241,902	382,552	484,873	608,921	704,526
National Institutes of Health					
NCI	1,954	2,082	2,077	2,075	2,117
NHLBI	24,188	34,805	30,558	31,584	32,102
NIDR	281	285	—	—	—
NIDDK	—	1,500	1,080	1,130	1,140
NINDS	11,458	11,488	11,723	12,042	12,182
NIAD	92,078	96,160	81,438	95,097	96,998
NICHD	78,321	76,405	84,818	98,400	88,800
NIE	3,809	3,410	3,989	4,185	4,252
NIEHS	8,411	6,188	5,740	5,970	6,136
NIAMS	11,002	8,633	8,519	10,255	10,470
NIDCO	1,813	2,089	2,194	2,835	2,861
NIMH	2,848	3,222	2,898	3,173	3,238
NIDA	46,200	47,300	46,401	48,000	48,800
NIALLA	8,852	7,201	5,938	6,130	6,200
NCRR	8,125	8,722	8,640	10,533	10,533
NINR	8,021	4,593	4,472	4,700	4,800
NCHRR	—	7,838	13,272	14,021	14,504
FIC	1,132	847	1,458	1,552	1,552
National Institutes of Health	301,473	324,838	327,109	341,462	346,565
Substance Abuse and Mental Health Services Administration	80,253	72,817	57,149	32,441	26,688
Agency for Health Care Policy and Research	8,086	8,768	8,083	4,747	5,450 1/
Family Planning	540	575	520	525	530
Subtotal, LHHS PHS Agencies	1,406,754	1,618,397	1,732,890	1,836,881	1,945,715
Health Care Financing Administration - Medicaid	5,400,000	6,800,000	7,000,000	7,800,000	8,100,000
Subtotal, LHHS Agencies	6,806,754	8,218,397	8,732,890	9,436,881	10,045,715
Indian Health Service	\$331,323	\$348,567	\$350,113	360,873	407,496
Total Infant Mortality	\$7,138,077	\$9,588,964	\$9,083,003	\$9,797,554	\$10,453,211

1/ AHCPR: Variation in funding level from 1996 to 1998 reflects shift of 1996 commitments into 1995.

LONG TERM CARE

Budget Authority
(Dollars in Thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
Substance Abuse and Mental Health Services Admin.	\$51	\$0	\$0	\$0	\$0
Agency for Health Care Policy Research	<u>\$4,141</u>	<u>\$6,661</u>	<u>\$9,867</u>	<u>\$6,938</u>	<u>\$12,800</u>
Subtotal, U/HHS PHS Agencies	\$4,192	\$6,661	\$9,867	\$6,938	\$12,800
Health Care Financing Administration	\$20,171,000	\$21,235,000	\$22,866,000	\$23,747,000	\$25,860,000
Administration on Aging	<u>\$5,061</u>	<u>\$4,500</u>	<u>\$5,000</u>	<u>\$5,000</u>	<u>\$5,000</u>
Total Long Term Care	\$20,180,253	\$21,246,161	\$22,880,867	\$23,758,938	\$25,877,800

Revised 5/8/96

MENTAL RETARDATION

Budget Authority
(Dollars in Thousands)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Health Resources & Services Administration	\$744	\$808	\$790	\$736	\$859
Centers for Disease Control & Prevention					
Lead-Based Paint Poisoning Prevention	29,683	34,683	36,409	36,409	36,409
Fatal Alcohol	5,024	5,844	5,844	6,344	6,344
Mild Retardation (Poverty-Associated)	414	3,144	3,672	3,672	3,672
Subtotal, CDC	35,121	43,671	45,925	46,425	46,425
National Institutes of Health (NIH)					
NHLBI	\$0	\$3,101	\$3,575	\$3,700	\$3,775
NINDS	16,580	17,796	15,170	15,924	16,188
NIAD	29,523	31,240	34,121	35,486	36,196
NICHD	53,021	55,097	57,708	60,300	61,300
NIA	0	1,270	1,319	1,350	1,370
NIMH	6,311	6,198	6,539	6,910	7,017
NIAAA	6,701	7,523	8,565	8,900	8,000
NCRR	856	911	969	1,075	1,075
NNR	0	140	146	150	180
NCHGR	0	5,031	6,531	6,899	7,137
Subtotal, NIH	111,992	128,307	134,643	140,694	143,218
Health Care Financing Administration	5,911,000	5,915,000	5,750,000	5,944,000	6,283,000
Subtotal HHS	8,058,857	8,987,788	8,931,358	8,131,855	8,473,582
Social Security Administration					
Estimated Benefit Payments from OASDI Trust Funds	3,825,000	4,135,000	4,411,000	4,732,000	5,072,000
Estimated General Fund Payment for Supplemental Security Income (Net) 1/	4,339,000	5,108,000	5,164,000	5,149,000	6,045,000
Subtotal, SSA	8,164,000	9,243,000	9,575,000	9,881,000	11,117,000
Total Mental Retardation	\$14,222,857	\$16,239,788	\$15,508,358	\$18,012,855	\$17,590,582

1/ Due to Federal legislation mandating check payment on a banking day, the SSI program made 13 monthly payments in FY 1994, will make 11 monthly payments in FY 1995, and will make 12 monthly payments in other fiscal years.

MINORITY HEALTH AND ASSISTANCEBudget Authority
(Dollars in Thousands)

	FY 1993 ACTUAL	FY 1994 ACTUAL	FY 1995 ACTUAL	FY 1996 POLICY	FY 1997 ESTIMATE
Health Resources & Services					
Administration:					
Direct	178,183	184,098	112,525	199,051	183,703
Indirect	536,514	573,764	595,181	602,738	608,182
Total	614,677	657,862	707,706	701,789	691,885
Centers for Disease Control & Prevention:					
Direct	71,543	79,108	86,804	86,171	86,161
Indirect	840,545	1,044,395	1,118,440	1,125,501	1,114,993
Total	912,088	1,123,503	1,205,244	1,211,672	1,201,154
National Institutes of Health:					
Direct	395,200	438,900	507,297	531,890	540,619
Indirect	580,972	702,383	704,799	734,906	746,960
Total	976,172	1,141,283	1,212,096	1,266,796	1,287,579
Substance Abuse & Mental Health Services Administration:					
Direct	840	840	859	0	0
Indirect	296,953	335,127	318,725	177,016	177,764
Total	297,793	335,967	319,584	177,016	177,764
Agency for Health Care Policy and Research:					
Direct	6,373	7,700	12,983	7,214	8,089
Indirect	0	0	0	0	0
Total	6,373	7,700	12,983	7,214	8,089

MINORITY HEALTH AND ASSISTANCE

	FY 1993 ACTUAL	FY 1994 ACTUAL	FY 1995 ACTUAL	FY 1996 POLICY	FY 1997 ESTIMATE
Office of Public Health and Science 1/:					
Direct	20,398	19,738	20,540	19,806	19,945
Indirect	0	0	0	0	0
Total	20,398	19,738	20,540	19,806	19,945
Health Care Financing Administration:					
Direct	0	0	0	0	0
Indirect	25,063,000	27,636,000	30,457,000	31,802,000	34,365,000
Subtotal	25,063,000	27,636,000	30,457,000	31,802,000	34,365,000
Subtotal, L/HHS					
Direct	572,517	630,384	741,018	744,132	738,517
Indirect	27,317,984	30,291,669	33,194,145	34,442,161	37,012,899
Total	27,890,501	30,922,053	33,935,163	35,186,293	37,751,416
Indian Health Service:					
Direct	1,858,630	1,943,070	1,960,074	1,999,800	2,174,200
Indirect	0	0	0	0	0
Total	1,858,630	1,943,070	1,960,074	1,999,800	2,174,200
TOTAL MINORITY HEALTH					
Direct	2,431,147	2,573,454	2,701,092	2,743,932	2,912,717
Indirect	27,317,984	30,291,669	33,194,145	34,442,161	37,012,899
TOTAL	29,749,131	32,865,123	35,895,237	37,186,093	39,925,616

1/ Formerly the Office of Assistant Secretary for Health

PEDIATRIC AIDS

Budget Authority
(Dollars in Thousands)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Health Resources and Services					
Administration	\$20,897	\$22,000	\$26,000	\$32,000	\$34,000
Centers for Disease Control and Prevention	44,862	47,862	47,802	47,374	47,374
National Institutes of Health					
NCI	11,404	10,667	9,460	8,843	8,111
NHLBI	8,790	17,668	9,120	9,621	9,552
NIDR	1,533	2,041	1,585	1,663	1,664
NIDDK	552	1,109	527	540	550
NINDS	1,528	1,870	1,975	1,981	1,983
NIAID	65,101	65,979	64,466	67,045	68,386
NICHD	33,649	44,087	43,823	45,400	45,000
NIMH	9,373	12,416	15,242	16,073	15,973
NIDA	3,580	2,794	4,051	4,300	4,400
NIAAA	805	2,821	2,365	2,400	2,400
NCRR	6,519	7,224	8,139	8,139	8,139
NINR	278	0	28	30	35
NCHGR	0	0	254	286	564
FIC	413	643	729	775	775
National Institutes of Health	143,525	169,319	161,794	166,995	167,532
Substance Abuse & Mental Health					
Services Administration	3,019	3,318	3,416	1,791	2,051
Agency for Health Care Policy and Research	700	1,700	1,400	700	700
TOTAL PEDIATRIC AIDS	\$213,003	\$244,199	\$240,412	\$248,861	\$251,657

RURAL HEALTH

Budget Authority
(Dollars in Thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
Health Resources and Services					
Administration	\$401,254	\$431,124	\$445,400	\$458,600	\$443,600
Centers for Disease Control and Prevention	21,129	21,129	21,129	20,200	20,200
National Institutes of Health					
NCI	28,047	29,212	30,888	31,273	32,483
NHLBI	9,581	8,877	9,439	9,735	9,900
NIDR	810	484	1,141	1,262	1,282
NIEHS	1,422	1,911	1,732	2,135	2,220
NIA	6,712	5,378	6,079	6,230	6,320
NIMH	17,373	18,834	27,442	29,049	29,544
NIDA	5,567	5,957	5,277	5,500	5,800
NIAAA	0	3,021	3,891	3,850	3,900
NCRR	347	323	342	377	377
NCNR	2,927	2,501	3,428	3,650	3,700
NLM	6,544	6,333	6,307	6,502	6,502
National Institutes of Health	79,130	82,429	95,548	99,593	101,808
Agency for Health Care Policy and Research	3,289	4,278	9,272	5,288	5,132
Health Care Financing Administration	110,000	197,000	234,000	252,000	278,000
TOTAL RURAL HEALTH	<u>\$814,802</u>	<u>\$735,960</u>	<u>\$805,347</u>	<u>\$833,651</u>	<u>\$848,740</u>

SEXUALLY TRANSMITTED DISEASES
(EXCLUDING HIV/AIDS)

Budget Authority
(Dollars in Thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
Centers for Disease Control and Prevention	\$89,552	\$99,771	\$105,164	\$105,527	\$103,968
Agency for Health Care Policy and Research	195	0	0	0	0
National Institutes of Health (NIH)					
NCI	24,156	26,050	27,560	28,749	29,157
NHLBI	0	193	0	0	0
NIDR	448	622	813	843	859
NINDS	473	892	375	386	386
NIAD	52,743	59,608	66,972	69,651	71,044
NICHD	3,247	3,336	2,799	2,900	2,900
NEI	1,126	1,280	1,144	1,200	1,219
NIDA	1,000	885	720	750	750
NCRR	2,604	5,474	5,802	6,383	6,383
NCNR	0	0	0	0	0
National Institutes of Health	85,797	98,142	106,185	110,862	112,698
Total Sexually Transmitted Diseases	\$175,544	\$197,913	\$211,349	\$216,389	\$216,666

STROKE

Budget Authority
(Dollars in Thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
<u>National Institutes of Health</u>					
NHLBI	21,271	21,851	22,595	23,300	23,700
NIDR	0	0	351	375	388
NINDS	67,050	69,162	71,988	75,588	77,119
NIGMS	685	718	743	770	786
NICHD	910	1,427	1,729	1,800	1,800
NEI	844	1,065	727	763	755
NIEHS	0	0	240	250	260
NIA	4,066	6,854	6,598	6,760	6,860
NIDCD	5,472	5,785	4,715	4,953	4,885
NIMH	3,371	2,775	3,096	3,279	3,348
NIDA	1,250	1,303	0	0	0
NIAAA	—	384	958	1,000	1,000
NCRR	651	450	480	532	532
NINR	1,201	603	76	80	90
National Institutes of Health	106,771	112,377	114,296	119,450	121,523
Agency for Health Care Policy & Research	1,533	2,194	300	300	250
Total Stroke	108,304	114,571	114,596	119,750	121,773

SUBSTANCE ABUSE

Budget Authority
(Dollars in thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996 1/</u>	<u>FY 1997</u>
Department of Health and Human Services					
Administration for Children and Families	\$111,200	\$105,700	\$110,300	\$58,900	\$96,600
Centers for Disease Control and Prevention	31,242	36,642	44,493	44,084	61,084
Food and Drug Administration	6,575	6,664	6,800	6,800	6,800
Health Care Financing Administration 2/	850,000	950,000	1,070,000	1,200,000	1,340,000
Health Resources and Services Administration 3/	20,880	33,442	36,418	41,494	43,287
Indian Health Service 4/	92,062	93,369	94,395	94,711	96,530
Substance Abuse and Mental Health Svcs Administration 5/	1,626,055	1,705,576	1,729,290	1,446,650	1,652,566
National Institutes of Health:					
NIDA	403,065	424,315	436,928	458,441	466,325
NIAAA	176,173	184,622	189,805	198,607	202,614
NIMH	65,371	66,784	63,940	67,662	68,771
Sub-Total, NIH (Non-Add)	(644,609)	(675,721)	(690,673)	(724,710)	(737,710)
Sub-Total, HHS	3,382,623	3,807,114	3,782,369	3,617,349	4,034,577
All Other Government 6/					
Department of Agriculture	28,900	30,700	29,300	28,100	29,000
Corporation for National Service	9,700	28,200	25,600	32,900	38,500
Department of Defense	1,140,700	814,900	840,200	814,300	814,100
Department of Education	700,800	598,800	584,000	618,100	658,800
Department of Housing and Urban Development	175,000	315,000	300,800	290,000	290,000
Department of the Interior	40,600	38,400	35,900	35,400	35,500
The Federal Judiciary	405,600	457,100	471,400	506,600	577,300
Department of Justice	4,803,300	4,963,500	5,794,300	6,436,900	7,141,000

SUBSTANCE ABUSE

Budget Authority
(Dollars in thousands)

	FY 1993	FY 1994	FY 1995	FY 1996 1/	FY 1997
Department of Labor	65,100	91,100	60,000	60,900	60,900
Office of National Drug Control Policy	116,400	110,500	146,100	129,900	137,800
Small Business Administration	200	200	100	100	100
Social Security Administration	4,000	18,800	147,900	196,400	202,800
Department of State	200,200	114,900	118,400	135,300	194,000
Agency for International Development	139,800	44,900	19,800	0	0
Department of Transportation	355,300	371,000	348,300	379,900	397,100
Department of the Treasury	1,040,500	1,094,700	1,068,300	1,074,100	1,112,100
U. S. Information Agency	9,300	7,900	9,800	9,100	9,300
Department of Veterans Affairs	901,500	854,100	966,500	1,009,100	1,056,000
Other Crime Control Acts	0	0	300	400	1,800
Sub-Total, All Other Govt	10,136,900	9,954,700	10,967,000	11,757,500	12,756,100
TOTAL, Substance Abuse	\$13,519,523	\$13,581,814	\$14,749,369	\$15,374,849	\$16,790,677

FOOTNOTES:

- 1/ FY 1996 is based on Presidential Policy funding levels.
- 2/ Corrects all years for overstated levels reported in FY 1996 Moyer table.
- 3/ Includes the Ryan White AIDS Care-Treatment funding.
- 4/ IHS data has been updated for prior years to include all Alcoholism and Substance Abuse Prevention/Treatment Program funding authorized under P.L. 103-572.
- 5/ Includes the Substance Abuse Prevention and Treatment Block Grant funding, serving both drug and alcohol programs, and total funding of the Centers for Substance Abuse Prevention/Treatment.
- 6/ Reflects funding data as reported by ONDCP in the 1996 National Drug Control Strategy. In general, it includes alcohol programs relating to illegal use of alcohol by underage persons.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

1 20.

Administration on Aging

FY 1996 Legislative Programs (Dollars in Thousands)

	1993 <u>Actual</u>	1994 <u>Actual</u>	1995 <u>Actual</u>	1996 <u>Estimate</u>	1997 <u>Estimate</u>
Office of the Secretary (Older Americans Act)					
A. Title II, Federal Council on Aging	\$177	\$177	\$176	\$226	\$226
B. Administration on Aging					
Title II-B Supportive Services	296,944	306,711	306,711	294,787	294,787
Title III, Part C-1, Congregate Nutrition	363,235	375,809	375,809	357,019	357,018
Title III, Part C-2 Home-delivered Meals	89,659	93,665	94,065	94,191	94,191
Title III, Part D Aging In-Home Services	7,075	7,075	8,263	9,263	9,263
Title III, Sec. 303(f) Preventive Health Services	16,864	17,032	16,982	16,982	16,982
Title VII, Sec. 702(a),					

Aging Ombudsman Services	3,870	4,370	4,449	4,449	4,449
Title VII, Sec. 702(b) Aging Elder Abuse Preventive	4,348	4,048	4,732	4,732	4,732
Title VII, Sec. 741, Outreach, Public Benefit and Insurance Counseling 1/	—	2,000	1,976	1,976	1,976
Title IV, Training, Research and Discretionary Programs	25,683	25,735	25,570	12,018	11,966
Title VI, Part A, Grants to Native Americans and Alaskan Natives	13,589	15,212	15,212	14,451	14,451
Part B, Native Hawaiians	1,511	1,680	1,680	1,686	1,686
White House Conference on Aging	—	1,000	2,961	0	0
TOTAL Programs on Aging, AoA	\$622,875	\$655,124	\$655,596	\$611,760	\$611,348

1/ FY 1994 is the first year funds were awarded for this activity.

CHILD CARE

Budget Authority
(Dollars in Millions)

	1993 Actual	1994 Actual	1995 Actual	1996 Policy a/	1997 Estimate
Administration for Children and Families (ACF)					
AFDC and Transitional Child Care	\$595.6	\$730.5	\$854.8	\$1,069.0	\$1,147.0
At-Risk Child Care	\$264.3	\$276.0	\$296.7	\$335.0	\$300.0
Comprehensive Child Development Centers	\$46.8	\$46.8	-	-	-
Child Care and Development Block Grant	\$892.7	\$892.7	\$834.6	\$934.6	\$1,048.8
Community Services Block Grant 1/	n/a	n/a	n/a	n/a	n/a
Social Services Block Grant (Title XX) 2/	\$660.0	\$660.0	\$660.0	\$660.0	\$660.0
Dependent Care Planning and Development	\$12.9	\$12.9	\$12.8	-	-
Child Development Associate Scholarship	\$1.4	\$1.4	\$1.4	-	-
Temporary Child Care Crisis Nurseries	\$11.9	\$11.9	\$11.8	\$9.8	-
Research and Demonstration	\$0.0	\$0.0	\$0.3	\$0.0	\$0.0
Head Start 3/	[2,776.3]	[3,325.7]	[3,534.1]	[3,631.0]	[3,981.0]
Subtotal, ACF	\$2,485.6	\$2,632.2	\$2,772.4	\$3,008.4	\$3,155.8
Public Health Service Research and Demonstration	\$11.5	\$11.1	\$10.3	\$10.6	\$10.6
Subtotal, PHS 4/	\$11.5	\$11.1	\$10.3	\$10.6	\$10.6
Assistant Secretary for Planning and Evaluation Research and Evaluation	\$0.3	\$0.3	\$0.2	\$0.2	\$0.2
HHS TOTAL	\$2,497.4	\$2,643.6	\$2,782.9	\$3,019.2	\$3,166.6

1/ The Community Services Block Grant provides grants to States to go to local community action agencies for local antipoverty activities, which may include child care. No data on such expenditures is provided to the Federal government.

2/ Estimates based upon HHS-sponsored research have been used for the cost of day care services which States may choose to provide under the Social Security Act's Title XX formula grants program.

3/ Data for the Head Start program are listed for information, but have not been included in totals for the Administration for Children and Families (ACF) because Head Start is a comprehensive child development program rather than a child care program.

4/ Based on levels of the ninth CR, including an incremental policy adjustment.

5/ Previous tables (FYs 1991-1994) have mistakenly attributed Agency for Health Care Policy and Research funding for children as funding for child care.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Population Research and Family Planning Activities
Budget Authority: Fiscal Year 1993 to Fiscal Year 1997
(Dollars in Millions)

PUBLIC HEALTH SERVICE (PHS)	FY 93	FY 94	FY 95	FY 96	FY 97
Office of Public Health and Science 1/					
Office of Population Affairs					
Family Planning Program	\$173.4	\$180.9	\$193.3	\$193.0	\$198.5
National Institutes of Health					
National Institute of Child Health and Human Development	\$154.9	\$165.4	\$169.4	\$176.9	\$179.6
Office of the Director	\$0.1	\$0.8	\$0.8	\$0.8	n/a
Health Resources and Services Administration					
Maternal and Child Health Block Grant	2/	2/	2/	2/	2/
Centers for Disease Control & Prevention	\$2.2	\$3.2	\$3.2	\$3.2	\$3.2
Indian Health Service	\$44.4	\$40.1	\$40.7	\$40.7	\$40.7
Sub-total PHS	\$375.0	\$390.4	\$407.4	\$414.6	\$422.0
Administration for Children & Families	3/	3/	3/	3/	3/
Health Care Financing Administration					
Medicaid Bureau	\$540.0	\$515.0	\$520.0	\$525.0	\$530.0
TOTAL DHHS	\$915.0	\$905.4	\$927.4	\$939.6	\$952.0

1/ Formerly the Office of the Assistant Secretary for Health

2/ The Maternal and Child Health Block Grant expends approximately \$560 million annually for a broad range of maternal and child health service, including family planning services. The proportion of this total allocated to family planning services cannot be determined through available reporting systems.

3/ The Social Services Block Grant expends over \$2.9 billion annually for a broad range of social services, including family planning. The proportion of this total allocated to family planning services cannot be determined through current reporting systems.

HEALTH CARE FINANCING ADMINISTRATION

ABORTIONSPart I - Background

HHS's Appropriations Acts have contained restrictions on the Department's funding of abortions since the Appropriations Act for FY 1977. HHS was enjoined by a Federal District Court from enforcing the FY 1977 restrictions until August 4, 1977. Consequently, the Department provided funding for all abortions which were covered under a State's plan that were performed through that date. The appropriations restrictions, commonly known as the Hyde Amendment restrictions, have governed HHS's funding of all abortions performed after August 4, 1977, except for those abortions performed during the period February 19 through September 19, 1980. Federal funding was available for all medically necessary abortions performed during that period under the criteria set forth by the District Court for the Eastern District of New York and described in Harris v. McRae, 448 U.S. 297 (1980).

The following excerpts from instructions issued by HHS set forth the rules under which the Department has funded abortions performed after August 4, 1977, with its appropriations for FY 1977 through FY 1980.

1. For abortions performed after August 4, 1977, and for which funds appropriated by the appropriations act for FY 1977 or the continuing resolutions which appropriated funds through December 1, 1977, are used to pay the claim:

"... where the attending physician, based on his or her professional judgment, has certified in writing that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term."

2. For abortions performed after August 4, 1977, and prior to February 14, 1978, and for which funds appropriated by P.L. 95-205 (appropriations act for FY 1978) or P.L. 95-480 (appropriations act for FY 1979) are used to pay the claim:

- (a) where the attending physician, based on his or her professional judgment, has certified in writing that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term;
- (b) where two physicians, based on their professional judgment, have certified in writing that severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term; or

Page 2 - Abortions

- (c) for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service.

The Department will accept any reasonable interpretation of those provisions for abortions covered under paragraph 2.

3. For abortions performed on or after February 14, 1978, and prior to August 21, 1978, and for which funds appropriated by P.L. 95-205 or P.L. 95-480 are used to pay the claim:

- (a) where a physician has found, and so certified in writing to the State agency, that on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term;
- (b) where two physicians have found, and both certified in writing to the State agency, that on the basis of their professional judgment, severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term; or
- (c) for the victims of rape or incest, if the State agency has received signed documentation from a law enforcement agency or public health service stating that:
 - (i) the person upon whom the medical procedure was performed was reported, within sixty (60) days of the incident, to have been the victim of an incident of rape or incest; and
 - (ii) the report included the name, address, and signature of the person who reported the rape or incest.

4. For abortions performed on or after August 21, 1978, and for which funds appropriated by P.L. 95-205 or P.L. 95-408 are used to pay the claim:

- (a) where a physician has found, and certified in writing to the State agency, that on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient;

Page 3 - Abortions

- (b) where two physicians have found, and certified in writing to the State agency, that on the basis of their professional judgment, severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term. The certification must contain the name and address of the patient. At least one of the two physicians must also certify that he or she is not an "interested physician." An "interested physician" is one:
 - (i) whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or
 - (ii) who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or
- (c) for the victims of rape or incest, if the State agency has received signed documentation from a law enforcement agency or public health service stating:
 - (i) that the person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest;
 - (ii) the date of the incident;
 - (iii) the date of the report, which must be within sixty (60) days of the incident;
 - (iv) the name and address of the victim and the name and address of the person making the report (if different from the victim); and
 - (v) that the report included the signature of the individual who reported the incident.

Page 4 - Abortions

The continuing resolutions which made funds available for FY 1980, P.L. 96-86 signed October 12, 1979, and P.L. 96-123 signed November 20, 1979, removed the exception which allowed payment for abortions in those instances where severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians. Thus, Federal funding for abortions was prohibited except: (1) where the life of the mother would be endangered if the fetus were carried to term, and (2) for such medical procedures necessary for victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service. Regulations implementing P.L. 96-86 were published at 42 CFR, part 441, on October 26, 1979. These regulations also applied to expenditures for abortions under P.L. 96-123 because the provision in that act governing abortions was similar to the one contained in P.L. 96-86.

On January 15, 1980, the District Court for the Eastern District of New York declared the Hyde Amendment unconstitutional insofar as it precluded payments for medically necessary abortions. That decision became effective on February 19, 1980, when the Supreme Court refused to extend a stay of the district court order. Federal funding then became available for all medically necessary abortions performed on or after February 19. The Supreme Court decision of June 30, 1980, reversed the district court's decision on the constitutionality of the Hyde Amendment. The petition for rehearing filed by the plaintiffs in the *McRae* case delayed the effective date of the Supreme Court's decision, leaving the district court order on payments for abortions in effect. The Supreme Court denied the appellee's petition for a rehearing in the *McRae* case on September 17, 1980, and the district court's order was vacated on September 19, 1980. Therefore, the availability of Federal funding for abortions performed after September 19, 1980, was subject to the FY 1980 Hyde Amendment restrictions; i.e., Federal funds under Medicaid were available only for abortions performed in life endangering circumstances and abortions performed in instances of promptly reported rape or incest.

On October 1, 1980, the President signed a joint resolution making continuing appropriations available for FY 1981 through December 15, 1980, or until the enactment of a subsequent appropriation. This resolution contained language which changed the conditions under which Federal funding was available for abortions under Medicaid. During FY 1980, Federal funds were available for abortions necessary for the victims of rape or incest when the rape or incest was reported to a law enforcement agency or public health service within sixty days.

Page 5 - Abortions

Under the FY 1981 resolution, Federal funds were available for abortions necessary for the victims of rape when the rape had been reported within 72 hours to a law enforcement agency or public health service. Federal funds were also available for abortions necessary for the victims of incest. There was no longer a reporting requirement for victims of incest. In cases of incest, Federal funding was available when the State agency had received a physician's written statement that the physician had been informed that the patient was a victim of incest. As in FY 1980, Federal funds continued to be available for abortions where the life of the woman would be endangered if the fetus were carried to term.

On June 5, 1981, the President signed the Supplemental Appropriations and Rescission Act of 1981. Under this act, Federal Financial Participation (FFP) is no longer available for abortion claims paid after June 5, 1981, for victims of rape or incest. Federal funds continue to be available for abortions where the life of the mother would be endangered if the fetus were carried to term.

Subsequent congressional measures have continued to make Federal funds available for abortions where the life of the woman would be endangered if the fetus were carried to term. See P.L. Nos. 97-51, 97-92, 97-276, 97-377, 98-107, 98-139, 98-619, 99-107, 99-154, 99-434, 99-464, 99-465, 99-491, 99-500, 99-591, 100-202, 100-436, 101-166, 101-517, 102-170 and 102-394.

Effective October 1, 1993, as part of Public Law No. 103-112, The Health and Human Services Appropriation bill, Congress passed a revision of the Hyde Amendment pertaining to Federal funding of abortions under the Medicaid program. Federal funding (FFP) is now available for abortions performed to save the life of the mother or to terminate pregnancies resulting from rape or incest when the claim for such an abortion is paid by the State on or after October 1, 1993. Please note that it is the date that the State pays the claim and not the date of the service which determines the availability of FFP.

Subsequent congressional measures have continued to make Federal funds available for abortions performed to save the life of the mother or to terminate pregnancies resulting from rape or incest when the claim for such an abortion is paid by the State on or after October 1, 1993. See P.L. No. 103-333.

Page 6 - Abortions

Part II - Data on Medicaid Financed Abortions

Following the implementation, on February 14, 1978, of regulations which resulted from the Hyde Amendment, a specific reporting procedure was developed for reporting information on Medicaid financed abortions. Data are reported quarterly by the States on the numbers of abortions and the allowable abortion-related expenditures. Data on the number of reported abortions for FYs 1978 - 95 are given in table 1 while expenditure amounts are given in table 2.

Since February 14, 1978, 61,098 Medicaid financed abortions have been reported by 49 jurisdictions through September 30, 1995. Total Medicaid expenditures, including Federal and State shares, for abortions have been \$18,651,619 during the period February 14, 1978 through September 30, 1995. Six jurisdictions (American Samoa, Hawaii, New York, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands) have not claimed Federal funds for abortions. California has submitted claims for FFP for abortions but has subsequently withdrawn these claims.

Of the 56 jurisdictions which reported for the period October 1, 1994 through September 30, 1995 (FY 1995), 21 jurisdictions claimed FFP under the Medicaid program for 204 abortions at a cost of \$348,115 including both Federal and State shares. By comparison, 21 jurisdictions claimed FFP under the Medicaid program in FY 1994 for 235 abortions at a cost of \$459,111 including both Federal and State shares. Of the 204 abortions claimed in FY 1995, 168 were due to endangerment to the life of the mother, 31 were due to rape and 5 were due to incest.

All abortion claims are subject to review by regional office staff. All claims found not to meet the applicable Federal criteria for FFP will be either withdrawn by the State or disallowed by HCFA.

The Health Care Financing Administration has not collected information on the number of abortions provided to Medicaid recipients where the State did not claim FFP, or on the number of federally financed Medicaid abortions prior to the implementation of the regulations on the Federal financing of abortions on February 14, 1978.

The abortion data in the attached tables reflect the most current information available as of March 6, 1996. Because States submit revised abortion claim data, the data contained in this report may differ with information contained in reports previously issued.

TABLE 1
TOTAL NUMBER OF REPORTED MEDICAID ABORTIONS BY STATE AND FEDERAL FISCAL YEAR
FEBRUARY 14, 1978 - SEPTEMBER 30, 1995 1/

	TOTAL	FY 78 2/	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
TOTAL	81,096	1,335	3,675	33,825	17,486	783	880	863	885	232	81
ALABAMA	621	15	53	203	229	15	20	17	10	12	7
ALASKA	84	84	0	0	0	0	0	0	0	0	0
AMERICAN SAMOA 3/	0	0	0	0	0	0	0	0	0	0	0
ARIZONA 4/	1	0	0	0	0	0	0	0	0	0	0
ARKANSAS	331	9	8	204	72	10	8	9	5	3	1
CALIFORNIA	0	0	0	0	0	0	0	0	0	0	0
COLORADO	2,165	121	217	818	818	178	168	88	74	0	0
CONNECTICUT	1,304	77	225	883	338	21	8	18	9	7	2
DELAWARE	338	0	1	279	29	1	3	2	6	6	2
DISTRICT OF COLUMBIA	2,759	0	0	2,417	343	0	0	0	0	0	0
FLORIDA	1,315	12	9	735	484	35	13	3	8	13	6
GEORGIA	944	8	8	771	17	28	8	3	0	7	5
GUAM	6	0	1	4	0	0	0	0	0	0	0
HAWAII	0	0	0	0	0	0	0	0	0	0	0
IDaho	108	15	7	37	18	3	2	3	8	1	2
ILLINOIS	3,250	205	138	2,143	885	19	20	5	8	2	2
INDIANA	649	4	0	812	13	2	1	7	1	1	0
IOWA	365	0	13	138	129	11	10	1	8	6	5
KANSAS	445	0	20	378	20	3	3	1	0	1	2
KENTUCKY	93	0	8	4	7	0	0	0	0	0	4
LOUISIANA	269	0	0	113	165	0	0	0	0	0	0
MAINE	294	2	0	129	195	8	3	0	7	5	5
MARYLAND	4,290	80	188	3,035	968	8	0	0	0	0	0
MASSACHUSETTS	8,800	0	1,137	4,627	3,129	7	0	0	0	0	0
MICHIGAN	108	0	0	0	0	0	0	0	0	0	0
MINNESOTA	1,819	0	0	949	804	13	2	2	4	3	3
MISSISSIPPI	13	12	1	0	0	0	0	0	0	0	0
MISSOURI	51	0	48	0	1	0	0	0	0	0	0
MONTANA	23	0	0	0	3	0	0	2	2	13	1
NEBRASKA	114	0	1	18	81	6	4	2	1	2	0
NEVADA	124	0	2	95	22	1	1	0	1	0	0
NEW HAMPSHIRE	84	1	5	51	27	0	0	0	0	0	0
NEW JERSEY	4,299	58	84	2,426	1,685	8	0	0	0	0	0
NEW MEXICO	232	2	6	143	79	2	0	0	0	0	0
NEW YORK	0	0	0	0	0	0	0	0	0	0	0
NORTH CAROLINA	1,483	9	8	834	395	17	11	22	11	12	5
NORTH DAKOTA	8	1	0	1	0	1	3	0	0	0	0
N. MARIANA IS.	0	0	0	0	0	0	0	0	0	0	0
OHIO	9,588	410	1,003	3,065	2,741	273	509	885	850	8	12
OKLAHOMA	391	19	182	77	78	1	1	0	0	0	0
OREGON	1,341	0	77	675	634	9	19	12	8	0	0
PENNSYLVANIA	8,481	85	134	5,651	3,347	52	31	26	37	108	0
PUERTO RICO	0	0	0	0	0	0	0	0	0	0	0
RHODE ISLAND	6	1	2	0	2	0	0	0	0	0	0
SOUTH CAROLINA	583	19	12	352	51	23	13	7	4	8	8
SOUTH DAKOTA	1	1	0	0	0	0	0	0	0	0	0
TENNESSEE	454	19	2	238	84	0	1	3	9	8	10
TEXAS	140	12	7	45	9	0	0	0	0	0	0
UTAH	280	2	1	184	80	18	11	6	0	0	0
VERMONT	200	3	13	89	51	2	0	2	0	2	2
VIRGIN ISLANDS	0	0	0	0	0	0	0	0	0	0	0
VIRGINIA	127	8	23	48	13	5	3	5	5	6	8
WASHINGTON	380	0	43	33	274	0	0	0	0	0	0
WEST VIRGINIA	3	3	0	0	0	0	0	0	0	0	0
WISCONSIN	1,843	1	1	1,402	197	9	8	4	2	2	0
WYOMING	3	1	0	1	0	0	0	0	0	0	0

1/ DATA FOR THIS REPORT ARE TAKEN FROM THE 84-3 FORMS SUBMITTED BY THE MEDICAID JURISDICTIONS AS PART OF THEIR QUARTERLY STATEMENT OF EXPENDITURES. THIS REPORT REFLECTS THE MOST CURRENT INFORMATION AVAILABLE AS OF MARCH 6, 1988. BECAUSE THE STATES SUBMIT REVISED ABORTION CLAIM DATA, THE DATA CONTAINED IN THIS REPORT MAY DIFFER WITH INFORMATION CONTAINED IN REPORTS PREVIOUSLY ISSUED.

2/ DATA FOR FY 1978 ARE ONLY FOR THE PERIOD FROM FEBRUARY 14, 1978 THROUGH SEPTEMBER 30, 1978.

3/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1982.

4/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1979.

TABLE 1
TOTAL NUMBER OF REPORTED MEDICAID ABORTIONS BY STATE AND FEDERAL FISCAL YEAR
FEBRUARY 14, 1978 - SEPTEMBER 30, 1995 1/

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95
TOTAL	135	120	71	92	198	323	236	204
ALABAMA	18	2	5	0	1	2	7	7
ALASKA	0	0	0	0	0	0	0	0
AMERICAN SAMOA 3/	0	0	0	0	0	0	0	0
ARIZONA 4/	0	0	0	0	0	0	0	1
ARKANSAS	0	0	0	0	0	3	4	0
CALIFORNIA	0	0	0	0	0	0	0	0
COLORADO	0	0	4	7	2	9	3	4
CONNECTICUT	0	0	0	0	0	0	0	0
DELAWARE	2	0	2	0	2	1	0	8
DISTRICT OF COLUMBIA	0	0	0	0	0	0	0	0
FLORIDA	0	0	0	0	0	0	0	0
GEORGIA	8	2	0	0	0	0	0	0
GUAM	0	0	0	2	4	23	37	18
HAWAII	0	0	0	0	0	0	0	0
IDaho	7	0	2	0	1	1	6	0
ILLINOIS	5	5	5	2	9	15	37	64
INDIANA	0	0	1	0	2	3	1	1
IOWA	9	8	1	8	1	5	1	5
KANSAS	5	3	3	0	2	1	0	3
KENTUCKY	5	1	5	14	15	3	13	12
LOUISIANA	0	0	0	0	0	0	1	0
MAINE	5	2	3	5	4	1	3	8
MARYLAND	0	0	0	0	0	0	0	0
MASSACHUSETTS	0	0	0	0	0	0	0	0
MICHIGAN	0	0	4	18	21	18	19	25
MINNESOTA	0	4	8	3	9	2	3	0
MISSISSIPPI	0	0	0	0	0	0	0	0
MISSOURI	0	0	0	0	0	0	0	2
MONTANA	0	0	1	1	0	0	0	0
NEBRASKA	0	0	0	0	0	0	0	0
NEV	0	0	0	0	0	0	0	0
NH	0	0	0	0	0	2	0	0
NJ	0	0	0	0	0	0	0	0
NEW JERSEY	0	0	0	0	0	0	0	0
NEW MEXICO	0	0	0	0	0	0	0	0
NEW YORK	0	0	0	0	0	0	0	0
NORTH CAROLINA	4	10	4	4	11	13	10	5
NORTH DAKOTA	0	0	0	0	0	0	0	0
N. MARIANA IS	0	0	0	0	0	0	0	0
OHIO	41	72	0	0	15	53	49	2
OKLAHOMA	0	0	2	2	10	13	4	4
OREGON	0	0	0	0	0	0	0	0
PENNSYLVANIA	0	0	0	0	0	0	0	0
PUERTO RICO	0	0	0	0	0	0	0	0
RHODE ISLAND	0	0	0	0	0	0	0	0
SOUTH CAROLINA	8	8	10	8	18	13	14	18
SOUTH DAKOTA	0	0	0	0	0	0	0	0
TENNESSEE	5	2	8	7	21	20	8	4
TEXAS	0	0	8	8	12	18	13	10
UTAH	0	0	0	0	5	6	0	0
VERMONT	0	0	0	1	1	0	2	2
VIRGIN ISLANDS	0	0	0	0	0	0	0	3
VIRGINIA	5	0	0	0	0	0	0	0
WASHINGTON	0	0	0	0	0	0	0	0
WEST VIRGINIA	0	0	0	0	0	0	0	0
WISCONSIN	0	1	0	2	4	2	1	0
WYOMING	0	0	0	0	0	1	0	0

1/ DATA FOR THIS REPORT ARE TAKEN FROM THE 64.9 FORMS SUBMITTED BY THE MEDICAID JURISDICTIONS AS PART OF THEIR QUARTERLY STATEMENT OF EXPENDITURES. THIS REPORT REFLECTS THE MOST CURRENT INFORMATION AVAILABLE AS OF MARCH 8, 1995. BECAUSE THE STATES SUBMIT REVISED ABORTION CLAIM DATA, THE DATA CONTAINED IN THIS REPORT MAY DIFFER WITH INFORMATION CONTAINED IN REPORTS PREVIOUSLY ISSUED.

2/ DATA FOR FY 1978 ARE ONLY FOR THE PERIOD FROM FEBRUARY 14, 1978 THROUGH SEPTEMBER 30, 1978.

3/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1982.

4/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1983.

5/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1979.

TABLE 2
TOTAL REPORTED EXPENDITURES FOR MEDICAID ABORTIONS BY STATE AND FEDERAL FISCAL YEAR
FEBRUARY 14, 1978 - SEPTEMBER 30, 1995 1/

	TOTAL	FY 78 2/	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
TOTAL	\$18,061,618	\$602,548	\$1,130,865	\$6,863,816	\$4,362,851	\$447,088	\$723,719	\$767,008	\$1,252,482	\$139,086	\$137,538
ALABAMA	186,874	4,334	11,703	48,720	48,498	4,387	9,248	5,856	1,982	2,542	1,952
ALASKA	38,331	38,331	0	0	0	0	0	0	0	0	0
AMERICAN SAMOA	0	0	0	0	0	0	0	0	0	0	0
ARIZONA 4/	905	0	0	0	0	0	0	0	0	0	0
ARKANSAS	98,247	1,726	8,975	49,475	21,957	4,032	6,988	8,270	857	3,344	188
CALIFORNIA	0	0	0	0	0	0	0	0	0	0	0
COLORADO	887,875	18,918	38,210	188,088	188,883	41,384	79,282	27,808	18,801	0	0
CONNECTICUT	881,720	35,821	78,384	255,233	110,378	11,384	9,888	9,357	4,875	4,915	588
DELAWARE	141,867	0	817	98,812	15,787	875	1,988	2,771	2,243	2,874	512
DISTRICT OF COLU	371,640	0	0	388,878	34,484	0	0	0	0	0	0
FLORIDA	288,748	4,218	983	187,847	91,887	20,063	13,862	2,114	12,288	8,515	18,718
GEORGIA	384,380	1,887	3,327	182,253	78,402	10,427	378	888	0	4,878	2,144
HAWAII	748	0	329	430	0	0	0	0	0	0	0
IDAH0	0	0	0	0	0	0	0	0	0	0	0
ILLINOIS	31,338	2,712	1,487	8,823	2,870	888	283	782	8,886	481	502
INDIANA	880,222	88,433	28,162	318,883	88,528	8,818	3,888	728	887	338	282
INDEA	138,571	2,854	0	118,818	3,470	872	150	10,077	150	280	0
IOWA	148,212	0	4,801	42,858	32,058	3,984	4,385	4,071	2,137	1,335	13,778
KANSAS	184,882	0	7,815	108,118	18,828	2,131	8,880	381	0	912	470
KENTUCKY	147,288	0	5,217	728	3,478	0	0	0	0	0	6,547
LOUISIANA	48,880	0	0	26,872	28,228	0	0	0	0	0	0
MAINE	180,862	1,328	1,811	48,063	36,763	1,882	8,136	0	8,141	2,542	2,517
MARYLAND	1,084,522	20,888	88,488	772,134	308,384	11,887	0	0	0	0	0
MASSACHUSETTS	1,117,351	0	83,048	567,880	475,811	801	0	0	0	0	0
MICHIGAN	388,848	0	0	8	8	0	0	0	0	0	0
MINNESOTA	303,880	0	0	142,771	142,885	2,288	108	433	1,821	383	88
MISSISSIPPI	780	720	80	0	0	0	0	0	0	0	0
MISSOURI	3,387	0	2,808	0	388	0	0	0	0	0	0
^ NA	8,735	0	0	0	784	0	0	488	1,587	2,638	218
KA	37,748	0	480	4,381	18,233	1,748	1,087	418	184	245	0
^	38,880	0	1,288	21,283	5,718	184	442	0	327	0	0
NEW HAMPSHIRE	12,318	100	887	7,188	4,158	0	0	0	0	0	0
NEW JERSEY	884,071	12,214	44,831	484,538	328,283	3,285	0	0	0	0	0
NEW MEXICO	42,380	380	1,185	24,378	18,258	883	0	0	0	0	0
NEW YORK	0	0	0	0	0	0	0	0	0	0	0
NORTH CAROLINA	788,684	4,878	8,828	214,185	117,848	10,842	10,370	30,313	28,848	12,242	12,688
NORTH DAKOTA	1,887	182	0	213	0	170	812	0	0	0	0
N. MARIANA I/	0	0	0	0	0	0	0	0	0	0	0
OHIO	8,184,318	230,871	837,158	880,378	1,188,188	242,384	843,758	833,823	1,128,048	20,712	34,355
OKLAHOMA	180,374	6,884	181,481	34,338	35,223	1,218	1,818	0	0	0	0
OREGON	187,373	1,192	7,708	38,827	83,852	1,324	2,187	1,828	845	0	0
PENNSYLVANIA	2,371,222	25,388	82,788	1,342,337	911,801	38,588	8,128	18,784	20,410	88,878	0
PUERTO RICO	0	0	0	0	0	0	0	0	0	0	0
RHODE ISLAND	8,887	884	2,328	0	2,177	8	0	8	0	0	0
SOUTH CAROLINA	388,811	4,878	3,872	81,487	17,823	13,878	8,480	8,313	8,888	4,813	3,258
SOUTH DAKOTA	282	282	8	8	0	0	0	0	0	0	0
^ TENNESSEE	188,223	2,875	881	38,507	12,347	0	117	810	0	3,880	22,228
TEXAS	182,848	8,878	3,182	11,170	3,788	0	0	0	0	0	0
UTAH	88,388	820	200	34,815	11,717	3,083	3,832	1,411	0	0	0
VERMONT	88,878	1,285	8,043	18,881	18,885	181	0	800	0	2,880	2,482
VIRGIN ISLANDS	0	0	8	0	0	0	0	0	0	0	0
VIRGINIA	67,820	1,134	7,238	18,742	4,188	8,875	8,488	2,228	8,181	780	3,880
WASHINGTON	88,881	0	8,870	2,848	88,878	8	0	0	0	0	0
WEST VIRGINIA	888	888	0	0	0	0	0	0	8	0	0
WISCONSIN	318,387	883	1,881	288,385	21,758	2,825	1,801	1,882	310	332	0
WYOMING	2,378	880	0	1,888	0	0	0	8	0	0	0

1/ DATA FOR THIS REPORT ARE TAKEN FROM THE 64-9 FORMS SUBMITTED BY THE MEDICAID JURISDICTIONS AS PART OF THEIR QUARTERLY STATEMENT OF EXPENDITURES. THIS REPORT REFLECTS THE MOST CURRENT INFORMATION AVAILABLE AS OF MARCH 8, 1988. BECAUSE THE STATES SUBMIT REVISED ABORTION CLAIM DATA, THE DATA CONTAINED IN THIS REPORT MAY DIFFER WITH INFORMATION CONTAINED IN REPORTS PREVIOUSLY ISSUED.

2/ DATA FROM FY 1978 ARE ONLY FOR THE PERIOD FROM FEBRUARY 14, 1978 THROUGH SEPTEMBER 30, 1978.

3/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1982.

4/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1983.

5/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1979.

TABLE 2
TOTAL REPORTED EXPENDITURES FOR MEDICAID ABORTIONS BY STATE AND FEDERAL FISCAL YEAR
FEBRUARY 14, 1978 - SEPTEMBER 30, 1995 1/

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95
TOTAL	\$211,307	\$224,192	\$102,827	\$187,380	\$289,180	\$411,799	\$469,111	\$348,116
ALABAMA	11,836	768	15,916	0	895	2,324	5,980	21,757
ALASKA	0	0	0	0	0	0	0	0
AMERICAN SAMOA	0	0	0	0	0	0	0	0
ARIZONA 4/	0	0	0	0	0	0	0	305
ARKANSAS	0	0	0	0	0	495	1,321	0
CALIFORNIA	0	0	0	0	0	0	0	0
COLORADO	0	0	745	1,899	1,954	5,538	918	915
CONNECTICUT	0	0	0	0	0	0	0	0
DELAWARE	844	0	17,568	0	844	697	0	2,598
DISTRICT OF COLUMBIA	0	0	0	0	0	0	0	0
FLORIDA	0	0	0	0	0	0	0	0
GEORGIA	19,311	9,270	0	14,800	5,090	25,783	27,999	15,094
GUAM	0	0	0	0	0	0	0	0
HAWAII	0	0	0	0	0	0	0	0
IDAHO	3,854	0	352	0	372	410	1,246	0
ILLINOIS	885	882	871	630	1,784	3,403	7,381	167,210
INDIANA	0	0	347	0	880	1,883	280	3,390
IOWA	15,427	9,740	2,434	5,439	3,943	2,971	3,988	5,011
KANSAS	2,708	1,929	3,318	0	900	3,354	0	890
KENTUCKY	14,407	184	11,389	25,038	32,888	8,790	19,022	19,898
LOUISIANA	0	0	0	0	0	0	0	0
MAINE	2,743	834	834	83,278	3,107	14,886	3,220	5,973
MARYLAND	0	0	0	0	0	0	0	0
MASSACHUSETTS	0	0	0	0	0	0	0	0
MICHIGAN	0	0	2,452	15,725	29,731	22,039	99,590	88,241
MINNESOTA	1,083	1,048	3,366	840	4,537	378	1,228	0
MISSISSIPPI	0	0	0	0	0	0	0	0
MISSOURI	0	0	0	0	0	0	0	150
MONTANA	0	0	876	196	0	0	0	0
NEBRASKA	0	0	0	0	0	0	0	0
NEW HAMPSHIRE	0	0	0	0	0	798	0	0
NEW JERSEY	0	0	0	0	0	0	0	0
NEW MEXICO	0	0	0	0	0	0	0	0
NEW YORK	0	0	0	0	0	0	0	0
NORTH CAROLINA	4,730	11,889	19,789	7,785	44,354	101,341	83,799	10,928
NORTH DAKOTA	0	0	0	0	0	0	0	0
N. MARIANA IS.	0	0	0	0	0	0	0	0
OHIO	139,916	171,384	0	0	36,510	129,653	171,315	12,094
OKLAHOMA	0	0	480	890	2,800	3,025	613	1,213
OREGON	0	0	0	0	0	0	0	0
PENNSYLVANIA	0	0	0	0	0	0	0	0
PUERTO RICO	0	0	0	0	0	0	0	0
RHODE ISLAND	0	0	0	0	0	0	0	0
SOUTH CAROLINA	3,825	7,868	14,885	21,098	27,243	20,967	21,745	42,931
SOUTH DAKOTA	0	0	0	0	0	0	0	0
TENNESSEE	19,769	9,706	3,539	15,919	19,320	29,120	12,630	5,893
TEXAS	0	0	8,953	20,489	26,845	18,899	54,911	21,898
UTAH	0	0	0	0	0	0	0	0
VERMONT	0	0	0	32	19,530	0	2,164	2,188
VIRGIN ISLANDS	0	0	0	0	0	0	0	0
VIRGINIA	4,361	0	0	0	0	0	0	987
WASHINGTON	0	0	0	0	0	0	0	0
WEST VIRGINIA	0	0	0	0	0	0	0	0
WISCONSIN	0	3,464	0	3,527	1,913	849	946	0
WYOMING	0	0	0	0	0	841	0	0

1/ DATA FOR THIS REPORT ARE TAKEN FROM THE 84-9 FORMS SUBMITTED BY THE MEDICAID JURISDICTIONS AS PART OF THEIR QUARTERLY STATEMENT OF EXPENDITURES. THIS REPORT REFLECTS THE MOST CURRENT INFORMATION AVAILABLE AS OF MARCH 9, 1999. BECAUSE THE STATES SUBMIT REVERSED ABORTION CLAIM DATA, THE DATA CONTAINED IN THIS REPORT MAY DIFFER WITH INFORMATION CONTAINED IN REPORTS PREVIOUSLY ISSUED.

2/ DATA FROM FY 1978 ARE ONLY FOR THE PERIOD FROM FEBRUARY 14, 1978 THROUGH SEPTEMBER 30, 1978.

3/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1982.

4/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1983.

5/ NO MEDICAID PROGRAM IN EFFECT UNTIL FY 1979.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Support for Performance of Medical and Health-Related R&D, by Source of Funds
Fiscal Years 1973-1993

Source of Funds	(Dollars in Millions)										
	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Total	\$3,750	\$4,443	\$4,701	\$5,107	\$5,508	\$6,282	\$7,133	\$7,953	\$8,723	\$9,541	\$10,778
Government	2,470	3,008	3,118	3,371	3,734	4,227	4,788	5,308	5,413	5,805	6,117
Federal	2,226	2,754	2,832	3,058	3,388	3,811	4,321	4,723	4,849	4,971	5,308
NIH	(1,323)	(1,737)	(1,887)	(1,087)	(2,287)	(2,581)	(2,953)	(3,182)	(3,333)	(3,439)	(4,081)
State and local	245	254	286	312	346	416	465	480	564	834	718
Industry	1,048	1,183	1,319	1,488	1,614	1,800	2,080	2,488	2,888	3,583	4,205
Private nonprofit	292	252	284	267	220	235	254	291	312	343	458
Foundations	75	79	86	76	71	65	60	54	52	44	89
Voluntary health	70	84	85	94	102	113	129	146	161	178	206
agencies											
Howard Hughes											
Med. Inst.	0	0	0	0	0	0	0	18	20	25	54
Other	87	89	83	97	47	57	65	73	79	96	107

NOTES:

- Excludes research training and construction.

- These figures report support for the direct conduct of biomedical research. In addition, H-HA's Office of Grants and Special Programs provides support for scientific career development, which is not included here.

NATIONAL INSTITUTES OF HEALTH
National Support for Performance of Medical and Health-Related R&D, by Source of Funds
 Fiscal Years 1984 - 1994
 (Dollars in Millions)

Source of Funds	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
TOTAL	\$12,160	\$13,567	\$14,898	\$16,233	\$19,003	\$20,918	\$23,095	\$25,886	\$29,240	\$31,032	\$32,919
Government	6,883	7,669	7,923	9,029	9,726	10,629	11,416	12,435	13,660	14,106	14,537
Federal	6,087	6,791	6,895	7,847	8,431	9,163	9,791	10,602	11,726	12,051	12,341
NIH	(4,257)	(4,928)	(5,005)	(5,852)	(6,292)	(6,778)	(7,136)	(7,696)	(8,407)	(9,763)	(10,328)
State and Local	796	878	1,028	1,182	1,295	1,466	1,625	1,833	1,934	2,055	2,196
Industry	4,771	5,360	6,193	7,105	8,438	9,407	10,719	12,361	14,397	15,711	17,108
Private nonprofit	506	538	782	799	839	882	960	1,090	1,183	1,215	1,276
Foundations	111	122	129	161	155	129	155	175	213	201	212
Voluntary health agencies	204	232	260	285	323	354	363	393	421	465	483
Howard Hughes	79	51	247	183	179	197	215	250	258	251	262
Medical Institute	112	133	146	170	182	202	227	272	291	298	319
Other											

NOTES:

1. This table excludes research training and construction.
2. These figures report support for the direct conduct of biomedical research. In addition, HHMI's Office of Grants and Special Programs provides support for scientific career development, which is not included here.

Source: NIH Data Book, 1994

DHHS - National Institutes of Health

History of Congressional Action on Budget Requests

Fiscal Year	Budget Estimate to Congress	Appropriation	Fiscal Year	Budget Estimate to Congress	Appropriation
1933	\$48,000	\$48,000	1971	\$1,118,584,000	\$1,212,847,000
1934	54,775	54,775	1972	1,359,873,000	1,506,156,000
1935	50,000	50,000	1973	1,619,780,000	1,762,565,000
1936	64,000	64,000	1974	1,576,770,000	1,790,425,000
1937	64,000	64,000	1975	1,835,110,000	2,092,897,000
1938	464,000	464,000	1976	1,980,474,000	2,302,126,000
1939	515,000	515,000	1977	2,165,047,000	2,544,078,000
1940	587,000	707,000	1978	2,596,077,000	2,842,936,000
1941	712,000	711,000	1979	2,884,720,000	3,189,976,000
1942	\$705,000	700,000	1980	3,185,928,000	3,428,935,000
1943	1,278,000	1,278,000	1981	3,512,320,000	3,569,406,000
1944	1,291,000	2,555,020	1982	3,310,985,000	3,641,875,000
1945	2,835,000	2,835,000	1983	3,748,771,000	4,023,969,000
1946	2,078,000	3,414,700	1984	4,091,958,000	4,493,588,000
1947	10,799,000	8,125,448 1/	1985	4,566,453,000	5,149,459,000
1948	22,403,000	28,876,000	1986	4,852,880,000	5,262,211,000
1949	45,701,460	37,668,000	1987	4,936,157,000	6,182,910,000
1950	40,567,000	50,167,000	1988	5,534,277,000	6,666,693,000
1951	49,845,000	47,334,750 2/	1989	7,122,837,000	7,144,767,000 7/
1952	53,386,000	52,447,291	1990	7,529,397,000	7,576,352,000
1953	55,005,000	59,030,750	1991	7,929,686,000	8,276,739,000 8/
1954	56,340,000	71,153,000	1992	8,774,886,000	8,921,687,000 9/
1955	71,128,000 3/	81,268,000	1993	10,579,684,000	10,326,604,000 10/
1956	72,525,000	80,457,000	1994	10,667,984,000	10,937,653,000 11/
1957	104,976,000	147,810,000	1995	11,473,000,000	11,299,522,000 12/
1958	154,966,000	171,966,000	1996	11,773,006,000	11,939,001,000 13/
1959	174,026,000	241,964,000	1997	12,406,300,000 14/	
1960	241,895,000	331,910,000			
1961	332,437,000	459,100,000			
1962	494,676,000	629,459,000			
1963	653,501,000	737,201,000			
1964	732,055,000	730,379,000			
1965	762,268,000	773,091,000			
1966	844,931,000	873,931,000			
1967	950,032,000	1,014,254,000			
1968	1,079,787,000	1,076,461,000			
1969	1,130,644,000	1,109,753,000			
1970	1,084,420,000	1,061,007,000			

- 1/ Includes \$386,000 in transfers
- 2/ Not less than \$3,000,000 was earmarked in liquidating cash; an additional \$1,175,000 was used for that purpose.
- 3/ Excludes \$3,218,280,000 rescinded.
- 4/ September budget; original request was \$3,762,483,000.
- 5/ Includes \$14,866,000 for AIDS research.
- 6/ Reflects transfer of AIDS research activities to OASH.
- 7/ Reflects transfer of \$7,443,000 for AZT to OASH.
- 8/ Reflects administrative reduction and sequestration.
- 9/ Reflects 2.41% reduction and NIH's share of \$50M for salaries and expenses.
- 10/ Reflects enacted administrative reduction of an across the board .8% decrease of \$83,571,000, salaries expenses reduction of \$34,857,000, and consultant services reduction of \$1,342,000. All columns have been adjusted to include the transfers from ADAMHA.
- 11/ Includes rescission of \$18,120,000
- 12/ Includes \$1,333,570,000 for HIV activities appropriated to the Office of AIDS Research. Reflects enacted reduction of \$7,446,000 for procurement, \$346,000 for rent, \$4,401,000 for bonus pay, \$10,000,000 for Extramural Construction in NCCR, and an administrative cost reduction of \$12,384,000.
- 13/ Includes \$1,407,824,000 for HIV research activities appropriated to the ICDs.
- 14/ Includes \$1,431,908,000 for HIV research activities in the Office of AIDS Research.

WOMEN'S HEALTH

Obligations
(Dollars in thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
Food and Drug Administration					
Direct	\$3,000	\$15,000	\$21,500	\$28,000	\$28,403
Indirect	---	---	---	---	---
Total, FDA	3,000	15,000	21,500	28,000	28,403
Health Resources and Services Administration					
Direct	428,698	462,137	511,756	485,710	492,012
Indirect	<u>458,847</u>	<u>486,616</u>	<u>502,094</u>	<u>506,061</u>	<u>508,026</u>
Total, HRSA	887,545	948,753	1,013,850	991,771	1,000,038
Indian Health Service					
Direct	105,418	110,945	118,497	118,498	124,716
Indirect	---	---	---	---	---
Total, IHS	105,418	110,945	118,497	118,498	124,716
Centers for Disease Control and Prevention					
Direct	129,986	158,244	188,857	242,889	242,307
Indirect	<u>55,515</u>	<u>57,024</u>	<u>66,075</u>	<u>64,198</u>	<u>66,133</u>
Total, CDC	185,501	215,268	254,932	307,087	308,440
National Institutes of Health					
Direct	1,337,379	1,548,684	1,701,625	1,799,258	1,827,018
Indirect	---	---	---	---	---
Total, NIH	1,337,379	1,548,684	1,701,625	1,799,258	1,827,018
Substance Abuse and Mental Health Services Administration					
Direct	153,870	160,023	157,733	125,110	119,759
Indirect	<u>77,030</u>	<u>74,312</u>	<u>65,755</u>	<u>38,239</u>	<u>37,308</u>
Total, SAMHSA	230,900	234,335	223,488	163,349	157,067
Agency for Health Care Policy and Research					
Direct	5,892	9,856	28,439	22,551	37,919
Indirect	---	---	---	---	---
Total, AHCPR	5,892	9,856	28,439	22,551	37,919
Office of Public Health and Science/Office of the Secretary					
Direct	7,598	7,175	9,220	8,696	8,757
Indirect	<u>1,739</u>	<u>2,914</u>	<u>2,322</u>	<u>2,455</u>	<u>2,800</u>
Total, OPHS/OS	9,337	10,089	11,542	11,151	11,557

WOMEN'S HEALTH

Obligations
(Dollars in thousands)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
Total, PHS					
Direct	\$2,171,841	\$2,472,064	\$2,737,627	\$2,830,712	\$2,880,891
Indirect	<u>593,131</u>	<u>620,866</u>	<u>636,246</u>	<u>610,953</u>	<u>614,267</u>
Total, PHS	2,764,972	3,092,930	3,373,873	3,441,665	3,495,158
Administration on Aging					
Direct	---	---	---	---	---
Indirect	<u>237,506</u>	<u>246,330</u>	<u>247,013</u>	<u>236,587</u>	<u>236,462</u>
Total, AoA	237,506	246,330	247,013	236,587	236,462
Health Care Financing					
Administration					
Direct	131,873,131	144,072,082	159,263,674	172,567,460	188,687,231
Indirect	<u>---</u>	<u>---</u>	<u>---</u>	<u>---</u>	<u>---</u>
Total, HCFA	131,873,131	144,072,082	159,263,674	172,567,460	188,687,231
Total, HHS					
Direct	134,044,972	146,544,146	162,001,301	175,398,172	191,568,122
Indirect	<u>830,637</u>	<u>867,196</u>	<u>883,259</u>	<u>847,540</u>	<u>850,729</u>
Total, HHS	\$134,875,609	\$147,411,342	\$162,884,560	\$176,245,712	\$192,418,851

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

Requests in the FY 1997 Budget for Which Legislative Authority has Expired or is Due to Expire on September 30, 1996

(Dollars in thousands)

APPROPRIATION/PROGRAM	EXPIRING AUTHORIZATION	AMOUNTS INCLUDED IN PRESIDENT'S BUDGET
CENTERS FOR DISEASE CONTROL AND PREVENTION		
Disease Control, Research, and Training:		
Chronic and Environmental Disease Prevention	Birth Defects 317 (d)	\$6,026
Immunization	Grants: PHSA Section 317(j)(1)(a)	\$358,903
NATIONAL INSTITUTES OF HEALTH		
National Research Service Awards	PHS Act, Section 487 (d)	\$404,975,000
Office of AIDS Research (Funds to be transferred to Institutes and Centers)	PHS Act, Title XXIII, Sec. 2351	\$1,431,908
Emergency Discretionary Fund	PHS Act, Title XXIII, Sec. 2356	\$10,000,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

Requests in the FY 1997 Budget for Which Legislative
Authority has Expired or is Due to Expire on September 30, 1996

(Dollars in thousands)

APPROPRIATION/PROGRAM	EXPIRING AUTHORIZATION	AMOUNTS INCLUDED IN PRESIDENT'S BUDGET
AGENCY FOR HEALTH CARE POLICY AND RESEARCH		
7561700-Health Care Policy and Research: Health Care Systems, Cost, & Access	PHSA, Title IX, Sec. 926(a)	\$29,132
Health Care Outcomes & Quality	PHSA, Title IX, Sec. 926(a)	\$42,445
Health Insurance & Expenditures Survey	PHSA, Title IX, Sec. 926(a)	\$10,000
Program Support	PHSA, Title IX, Sec. 301	\$2,423
Medicare Trust Fund Transfer *	SSA, Title XI, Sec. 1142(i)	\$4,802
Medicare Trust Fund Transfer *	SSA, Title XI, Sec. 201(g)	\$994

* This authorization expired 9/30/94.
All other authorization expired 9/30/95.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

Requests in the FY 1997 Budget for Which Legislative
Authority has Expired or is Due to Expire on September 30, 1996
(Dollars in thousands)

APPROPRIATION/PROGRAM	EXPIRING AUTHORIZATION	AMOUNTS INCLUDED IN PRESIDENT'S BUDGET
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Child Care and Development Block Grant	Section 658A-658R of the Omnibus Budget Reconciliation Act of 1981, as amended (expired 9/30/95)	\$934,642
Child Abuse State Grants	Section 114 of the Child Abuse Prevention and Treatment Act, as amended (expired 9/30/95)	\$22,854
Abandoned Infants Assistance Program	Section 104(a) of the Abandoned Infants Assistance Act of 1988, as amended (expired 9/30/95)	\$14,406
Native American Program SEDS	Section 816(a) of the Native American Programs Act of 1974, as amended (expired 9/30/95)	\$38,382

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

Requests in the FY 1997 Budget for Which Legislative
Authority has Expired or is Due to Expire on September 30, 1996

(Dollars in thousands)

APPROPRIATION/PROGRAM	EXPIRING AUTHORIZATION	AMOUNTS INCLUDED IN PRESIDENT'S BUDGET
Native Hawaiian Revolving Loan Fund	Section 803A(f)(1) of the Native American Programs Act of 1974, as amended (expired 9/30/94)	(\$1,000)
Developmental Disabilities State Grants	Section 130 of the Developmental Disabilities Assistance and Bill of Rights Act (expires 9/30/96)	\$70,438
Developmental Disabilities Protection and Advocacy	Section 143 of the Developmental Disabilities Assistance and Bill of Rights Act (expires 9/30/96)	\$26,718
Developmental Disabilities University Affiliated Programs	Section 156(a) of the Developmental Disabilities Assistance and Bill of Rights Act (expires 9/30/96)	\$18,979

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

Requests in the FY 1997 Budget for Which Legislative
Authority has Expired or is Due to Expire on September 30, 1996

(Dollars in thousands)

APPROPRIATION/PROGRAM	EXPIRING AUTHORIZATION	AMOUNTS INCLUDED IN PRESIDENT'S BUDGET
Developmental Disabilities Special Projects	Section 163(a) of the Developmental Disabilities Assistance and Bill of Rights Act (expires 9/30/96)	\$5,715
Native American Program Environmental Quality	Section 816(c) of the Native American Programs Act of 1974, as amended (expires 9/30/96)	NO AMOUNT GIVEN
OFFICE OF THE SECRETARY General Departmental Management Office of Public Health and Science: Adolescent Family Life Office of Minority Health	PHS Act, Title XX, Section 2001 PHS Act, Title XVII, Section 1707	\$6,144 \$19,806

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

FY 1977-1997

Full-Time Equivalents (FTE) Ceiling, Total FTE, and Total Employment

	1977	1978	1979	1980	1981	1982	1983
FTE Ceiling	133,904	136,160	145,523	143,166	144,402	134,729	133,996
Total FTE (End-of-Year)	145,455	146,620	156,210	154,800	146,365	140,460	140,089
Total Employment (End-of-Year)	129,811	132,358	136,820	135,009	138,386	131,394	132,867

	1984	1985	1986	1987	1988	1989	1990
FTE Ceiling	134,496	128,215	123,745	118,745	113,837	114,762	114,032
Total FTE (End-of-Year)	135,464	129,565	124,924	119,755	117,152	115,981	115,619
Total Employment (End-of-Year)	130,544	124,527	118,520	114,968	114,410	113,689	115,911

	1991	1992	1993	1994	1995	1996	1997
FTE Ceiling	102,025	104,879	104,256	103,570	34,804	34,804	34,804
Total FTE (End-of-Year)	99,172	102,573	103,883	102,546	35,113	35,113	35,113
Total Employment (End-of-Year)	102,353	102,737	97,461	100,405	35,106	35,106	35,106

NOTE: Does not include data for FDA and IHS. FY 1996 and FY 1997 FTE reflect authorized ceiling.

FY 1996 and 1997 employment are estimated amounts. SSA became an independent agency in FY 1995 and is not included in FY 1995 and beyond.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

Entertainment Fund Authorization and Amount Expended
FY 1996 and FY 1997

APPROPRIATION	AUTHORIZED IN FY 1996	EXPENDED IN FY 1996	FY 1997 BUDGET REQUEST
National Institutes of Health	\$1,000,000	\$1,000,000	\$1,000,000
Secretary	\$37,000	\$37,000	\$37,000
TOTAL	\$1,037,000	\$1,037,000	\$1,037,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES**SUMMARY**

New Programs in FY 1997 Budget

(Dollars in thousands)

APPROPRIATION / PROGRAM	FY 1997 BUDGET REQUEST
HEALTH RESOURCES AND SERVICES ADMINISTRATION	
Bureau of Primary Health Care:	
Primary Care:	
Programs for Special Populations	\$7,485
Health Professions:	
Health Professions Workforce Development Cluster	\$117,205
Enhanced Area Health Education Centers Cluster	\$35,000
Minority/Disadvantaged Health Professions Cluster	\$64,085
Primary Care Medicine and Public Health Training Cluster	\$80,000
Nursing Education/Practice Cluster	\$70,000
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION	
Knowledge Development and Application	\$414,219
Mental Health Performance Partnerships	\$275,420
Substance Abuse Performance Partnerships	\$1,271,957
HEALTH CARE FINANCING ADMINISTRATION	
Program Management:	
Health Coverage for the Temporarily Unemployed	\$1,519,000
Health Care Purchasing Cooperatives	\$25,000
ADMINISTRATION FOR CHILDREN AND FAMILIES	
Teen Pregnancy Prevention Initiative	\$30,000
Child Welfare Innovative Programs	\$39,178
OFFICE OF THE SECRETARY	
General Departmental Management	
Anti-Terrorism activities	\$5,000

T-5

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY
FY 1995-1997 UNOBLIGATED CARRYOVER BALANCES
and
FY 1995 LAPSED FUNDS
(Dollars in thousands)

APPROPRIATION	UNOBLIGATED BALANCES		LAPSED FUNDS FY 1995
	FY 1995	FY 1996	
Health Resources and Services Administration	\$281,196	\$293,422	\$551
Centers for Disease Control and Prevention	45,828	0	388
National Institutes of Health	142,245	0	2,243
Substance Abuse and Mental Health Administration	1,672	1,672	464
Agency for Health Care Policy and Research	13	17	0
Health Care Financing Administration	13,039,527	12,747,305	22,477
Administration for Children and Families	480,706	15,332	496,273
Administration on Aging	409	0	479
Office of the Secretary	781	210	1,449
TOTAL HHS (LABOR/HHS)	\$13,992,377	\$13,057,958	\$824,324

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY
 FY 1995-1997 UNOBLIGATED CARRYOVER BALANCES
 and
 FY 1995 LAPSED FUNDS
 (Dollars in thousands)

APPROPRIATION	UNOBLIGATED BALANCES		LAPSED FUNDS FY 1995
	FY 1995	FY 1996	
HEALTH RESOURCES AND SERVICES ADMINISTRATION			
Health Resources and Services	\$10,786	\$11,409	\$9,409
Health Professions Graduate Student Loan Guaranteed Loan Financing Acct.	152,501	217,033	272,199
Health Professions Graduate Student Loan Insurance Program	0	0	0
Health Professions Graduate Student Loan Insurance Fund Liquidating Acct.	26,070	0	0
Vaccine Injury Compensation	26,179	0	0
Medical Facilities Guarantee and Loan Fund	54,660	54,980	55,490
Health Centers Malpractice Claims Fund	11,000	10,000	4,000
TOTAL HRSA	281,196	293,422	341,098
CENTERS FOR DISEASE CONTROL AND PREVENTION			
Disease Control, Research, and Training	0	0	0
Buildings & Facilities	43,815	0	0
Los Angeles Earthquake	85	0	0
Subtotal	43,900	0	0
Cooperative Research and Development Agreements	1,665	0	0
Royalties	263	0	0
TOTAL CDC	45,828	0	388

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY
FY 1995-1997 UNOBLIGATED CARRYOVER BALANCES
and
FY 1995 LAPSED FUNDS
(Dollars in thousands)

APPROPRIATION	UNOBLIGATED BALANCES		LAPSED FUNDS
	FY 1995	FY 1996	FY 1997
NATIONAL INSTITUTES OF HEALTH			
National Cancer Institute	\$0	\$0	\$244
National Heart, Lung and Blood Institute	0	0	15
National Institute of Dental Research	0	0	3
National Institute of Diabetes and Digestive and Kidney Diseases	0	0	37
National Institute of Neurological Disorders and Stroke	0	0	130
National Institute of Allergy and Infectious Diseases	0	0	0
National Institute of General Medical Sciences	0	0	159
National Institute of Child Health and Human Development	0	0	85
National Eye Institute	0	0	70
National Institute of Environmental Health Sciences	0	0	70
National Institute on Aging	0	0	49
National Institute of Arthritis and Musculoskeletal and Skin Diseases	0	0	44
National Institute on Deafness and Other Communication Disorders	0	0	64
National Institute of Mental Health	0	0	27
National Institute on Drug Abuse	0	0	402
National Institute on Alcohol, Abuse and Alcoholism	0	0	187
National Institute of Nursing Research	0	0	11
National Center for Research Resources	735	0	48
National Center for Human Genome Research	0	0	93
Fogarty International Center	0	0	12
National Library of Medicine	0	0	166
Office of the Director	0	0	327

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY
 FY 1995-1997 UNOBLIGATED CARRYOVER BALANCES
 and
 FY 1995 LAPSED FUNDS
 (Dollars in thousands)

APPROPRIATION	UNOBLIGATED BALANCES			LAPSED FUNDS FY 1995
	FY 1995	FY 1996	FY 1997	
Buildings and Facilities	\$141,510	\$0	\$0	\$0
TOTAL NIH	142,245	0	0	2,243
SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION	1,672	1,672	1,672	464
AGENCY FOR HEALTH CARE POLICY AND RESEARCH	13	17	21	0
HEALTH CARE FINANCING ADMINISTRATION				
Grants to States for Medicaid Program Management	13,032,713 6,814	12,740,491 6,814	1,101,094 6,814	0 22,477
TOTAL HCFA	13,039,527	12,747,305	1,107,908	22,477
ADMINISTRATION FOR CHILDREN AND FAMILIES				
Family Support Payments to States	105,374	0	0	0
Low Income Home Energy Assistance	0	0	0	76
Refugee and Entrant Assistance	2,332	2,332	2,332	9,536
Community Services Programs	0	0	0	811
Interim Assistance to States for Legalization	\$0	\$0	\$0	\$0
Payments to States for AFDC Work Programs	0	0	0	288,243
Family Preservation & Support	0	0	0	118
Payments to States for Child Care & Development Block Grant	0	0	0	0
Social Services Block Grant	360,000	0	0	4

1-3

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY
 FY 1995-1997 UNOBLIGATED CARRYOVER BALANCES
 and
 FY 1995 LAPSED FUNDS
 (Dollars in thousands)

APPROPRIATION	UNOBLIGATED BALANCES			LAPSED FUNDS FY 1995
	FY 1995	FY 1996	FY 1997	
Children & Families Services Programs	\$13,000	\$13,000	\$13,000	\$3,189
Payments to States for Foster Care and Adoption Assistance	0	0	0	194,298
TOTAL ACF	480,706	15,332	15,332	496,273
ADMINISTRATION ON AGING				
Administration on Aging	0	0	0	479
White House Conference on Aging	409	0	0	0
TOTAL AOA	409	0	0	479
OFFICE OF THE SECRETARY				
General Departmental Management (including former OASH)	0	150	150	663
Office of Inspector General	781	60	0	235
Office for Civil Rights	0	0	0	391
Policy Research	0	0	0	160
TOTAL OS	781	210	150	1,449

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Summary

FY 1997 Legislative Programs
(Dollars in thousands)

APPROPRIATION / PROGRAM	BUDGET AUTHORITY	OUTLAYS
Substance Abuse and Mental Health Administration		
Knowledge Development and Application	\$414,219	\$414,219
Mental Health Performance Partnerships	275,420	275,420
Substance Abuse Performance Partnerships	1,271,957	1,271,957
TOTAL, SAMHSA	\$1,961,596	\$1,961,596
Agency for Health Care Policy and Research		
Research on Health Care Systems, Cost, & Access	\$29,132	\$38,865
Research on Health Care Outcomes & Quality	42,445	40,793
Health Insurance and Expenditures Surveys	10,000	9,916
Program Support	2,423	2,412
TOTAL, AHCPR	\$84,000	\$91,986
Health Care Financing Administration		
Grants to States for Medicaid	\$3,277,338	\$3,277,338
Payments to Health Care Trust Funds	7,867,000	7,867,000
TOTAL, HCFA	\$11,144,338	\$11,144,338
Administration on Aging		
Supportive Services and Centers	\$294,787	\$287,099
Aging Congregate Meals	357,019	354,385
Aging Home-Delivered Meals	94,191	92,864
Aging In-Home Services	9,263	9,286

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Summary

FY 1997 Legislative Programs
(Dollars in thousands)

APPROPRIATION / PROGRAM	BUDGET AUTHORITY	OUTLAYS
Preventive Health Services	\$16,982	\$16,188
Training, Research, and Discretionary Programs	11,666	15,524
Grants to Indian Tribes	18,057	15,830
Aging Ombudsman Services	4,448	4,274
Aging Elder Abuse Preventive	4,732	4,523
Outreach, Public Benefit and Insurance Counseling	1,976	1,936
Federal Council on Aging	226	225
Federal Administration	16,789	16,803
White House Conference on Aging	0	0
TOTAL, AOA	\$828,137	\$818,937
Office of the Secretary		
General Departmental Management		
Office of Public Health and Science:		
Adolescent Family Life	\$6,144	\$5,584
Office of Minority Health	19,806	18,711
TOTAL, OS	\$25,950	\$24,295

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

Total Budget Authority by Fund

FY 1977-1997
(Dollars in thousands)

FISCAL YEAR	GENERAL FUNDS	TRUST FUNDS	TOTAL
1977	\$24,673,677	\$81,182,631	\$105,856,308
1978	43,575,360	89,605,443	133,180,803
1979	46,766,315	102,101,736	148,868,051
1980	55,846,605	117,453,758	173,300,363
1981	62,263,073	134,584,179	196,847,252
1982	65,045,753	148,042,785	213,088,538
1983	70,529,310	184,526,993	255,056,303
1984	76,818,931	180,598,508	257,417,439
1985	81,367,272	198,190,768	279,558,040
1986	84,745,149	205,813,431	290,558,580
1987	91,308,604	227,711,463	319,020,067
1988	102,891,463	259,105,107	361,996,570
1989	114,906,850	286,122,344	401,029,194
1990	126,297,554	308,044,029	434,341,583
1991	151,861,431	327,919,130	479,780,561
1992	175,757,231	340,357,862	516,115,093
1993	199,542,489	353,550,293	553,092,782
1994	215,953,124	378,675,212	594,628,336
1995	179,739,924	2,263,705	182,003,629
1996	198,208,685	2,225,054	200,433,739
1997	220,137,209	2,299,400	222,436,609

NOTES:

1) SSA became an independent agency in FY 1995 and is not included in FY 1995 and beyond.

2) FY 1995 amounts do not reflect the \$60 million rescission to unobligated balances at the National Institutes of Health.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

Total Expenditures

FY 1977-1997

(Dollars in thousands)

FISCAL YEAR	GENERAL FUNDS	TRUST FUNDS	TOTAL
1977	\$24,075,665	\$85,081,662	\$109,157,327
1978	44,577,578	93,871,447	138,449,025
1979	47,372,654	104,085,672	151,458,326
1980	54,288,050	118,573,639	172,861,689
1981	60,689,217	135,316,823	196,006,040
1982	66,631,065	155,979,794	222,610,859
1983	74,027,403	170,849,266	244,876,669
1984	75,511,703	178,999,651	254,511,354
1985	81,712,485	189,444,841	271,157,326
1986	82,862,205	199,313,114	282,175,319
1987	89,361,488	208,141,522	297,503,010
1988	100,258,105	220,305,529	320,563,634
1989	112,845,083	233,677,675	346,522,758
1990	124,880,568	249,809,726	374,690,294
1991	145,844,771	274,286,274	420,131,045
1992	172,654,300	289,776,487	462,430,787
1993	189,150,303	306,742,863	495,893,166
1994	197,565,509	321,782,230	519,347,739
1995	177,548,704	2,198,735	179,747,439
1996	208,653,921	2,234,436	210,888,357
1997	227,093,088	2,242,995	229,336,083

NOTE: SSA became an independent agency in FY 1995 and is not included in FY 1995 and beyond.

T-9

DEPARTMENT OF HEALTH AND HUMAN SERVICES SUMMARY

Travel by Appropriation, FY 1995 - 1997
(Dollars in thousands)

APPROPRIATION	FY 1995	FY 1996	FY 1997
Health Resources and Services Administration	\$4,248	\$3,585	\$1,883
Centers for Disease Control and Prevention	15,894	16,357	16,622
National Institutes of Health	18,391	18,283	18,496
Substance Abuse and Mental Health Administration	1,816	1,133	778
Agency for Health Care Policy and Research	435	448	462
Health Care Financing Administration - Program Management	7,317	3,000	3,000
Administration for Children and Families	3,962	2,357	3,626
Administration on Aging	334	374	383
Office of the Secretary:			
General Departmental Management	1,586	1,165	1,296
(including former OASH)			
Office of Inspector General	2,566	1,523	1,404
Office for Civil Rights	125	127	189
Policy Research	74	85	85
TOTAL: HHS (Labor/HHS)	\$56,748	\$48,437	\$48,224

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

PROGRAM MANAGEMENT AND PROGRAM SUPPORT COSTS

FY 1994-1997

(Dollars in thousands)

OBJECT CLASSIFICATION		FY 1994 ACTUAL	FY 1995 ACTUAL	FY 1996 EST.	FY 1997 EST.
11.1	Personnel Compensation				
11.3	Full-time permanent	\$1,290,328	\$1,258,673	\$1,288,999	\$1,333,641
11.5	Other than full-time permanent	130,075	121,920	125,122	129,755
11.8	Other personnel compensation	53,172	44,198	40,756	42,883
11.9	Special personal services payment	67,432	78,397	83,931	88,284
12.1	Total, Personnel Compensation	1,541,007	1,503,188	1,538,808	1,594,563
13.0	Civilian personnel benefits	322,526	313,571	325,633	338,387
21.0	Benefits for former personnel	5,499	24,577	8,188	5,650
22.0	Travel and transportation of perso	51,972	55,211	48,086	49,391
23.1	Transportation of things	8,116	8,857	7,902	8,060
23.2	Rental payments to GSA	81,613	81,145	94,413	91,420
23.3	Rental payments to others	7,039	8,020	6,856	6,869
24.0	Communications, utilities, and miscellaneous charges	92,011	79,876	76,492	77,553
25.0	Printing and reproduction	37,040	61,208	29,600	29,484
26.0	Other services	4,365,695	4,540,108	4,598,757	4,940,149
31.0	Supplies and materials	331,490	232,193	255,521	275,529
32.0	Equipment	159,851	146,160	121,384	131,569
33.0	Land and structures	2,115	1,292	1,675	5,678
	Investments and loans	7,668	7,738	7,740	8,000
Total, HHS		\$7,013,642	\$7,063,144	\$7,121,055	\$7,562,302

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

ENTITLEMENT VS. DISCRETIONARY
and
REQUEST VS. APPROPRIATION

(Dollars in thousands)

	ENTITLEMENT	DISCRETIONARY	TOTAL
FY 1988			
Request	\$68,776,708	\$17,623,759	\$86,400,467
Appropriation	72,298,801	17,482,203	89,781,004
FY 1989			
Request	79,935,233	17,208,906	97,144,139
Appropriation	82,440,114	19,208,737	101,648,851
FY 1990			
Request	88,747,118	18,183,245	106,930,363
Appropriation	94,918,809	20,638,226	115,557,035
FY 1991			
Request	100,985,697	22,014,181	122,999,878
Appropriation	109,326,196	23,749,142	133,075,338
FY 1992			
Request	120,698,415	24,085,714	144,784,129
Appropriation	130,951,900	25,538,444	156,490,344
FY 1993			
Request	150,321,272	24,642,505	174,963,777
Appropriation	151,553,042	26,188,571	177,741,613
FY 1994			
Request	158,711,151	29,886,461	188,597,612
Appropriation	159,696,774	28,980,428	188,677,202
FY 1995			
Request	152,614,218	29,855,012	182,469,230
Appropriation	152,220,540	29,783,089	182,003,629
FY 1996			
Request	172,161,111	31,180,195	203,341,306
Appropriation	170,952,178	29,481,561	200,433,739
FY 1997			
Request	191,504,255	30,932,354	222,436,609

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY

ADMINISTRATIVE EXPENSES

FY 1995-1997

(Dollars in thousands)

	OBJECT CLASSIFICATION	FY 1995 ACTUAL	FY 1996 EST.	FY 1997 EST.
	<u>PERSONNEL COMPENSATION</u>			
11.1	Full-time permanent	\$1,258,673	\$1,288,999	\$1,333,641
11.3	Other than full-time permanent	121,920	125,122	129,755
11.5	Other personnel compensation	122,595	124,687	131,167
11.9	Total Personnel Compensation	1,503,188	1,538,808	1,594,563
12.1	Civilian personnel benefits	313,571	325,633	338,387
13.0	Benefits for former personnel	24,577	8,188	5,650
21.0	Travel	55,211	48,086	49,391
22.0	Transportation of things	8,857	7,902	8,060
23.2	Rental payments to others	8,020	6,856	6,869
23.3	Communications, utilities, and miscellaneous charges			
24.0	Printing and reproduction	79,876	76,492	77,553
25.1	Consulting Services	61,208	29,600	29,484
25.2	Other Services	95,684	100,984	112,860
26.0	Supplies and materials	2,872,665	2,880,430	2,945,525
	TOTAL HHS	\$5,170,972	\$5,177,584	\$5,322,934

This data should duplicate the data in the Congressional Justifications.

WITNESSES

	Page
Bane, M.J	387
Benson, W.F	891
McCarthy, J.F	891
Mosedale, Lee	157
Rosewater, Ann	387
Shalala, Hon. D.E	1
Torres-Gil, F.M	891
Vladeck, B.C	157
Walker, E.L	891
Williams, D.P	157, 387, 891

INDEX

	Page
Secretary of Health and Human Services	1
Acquired Immunodeficiency Syndrome:	
Office of AIDS Research	49
Performance Partnership	68
Research	52, 70
Anti-Terrorism Funds	111
Breast and Cervical Cancer:	
Performance Partnership	69
Screening	38, 51, 130
Budget:	
Reductions	64
Cancer:	
Research	52, 71
Chronic Fatigue Syndrome	86
Coordinated Services:	
Between Federal Agencies	25
Children and Families	140
Developmental Disabilities	107
Emergency Assistance	67, 119
Financial and Programmatic Management	117
Firearm Injury:	
Prevention	53
Study	52, 53
Health Insurance for the Temporarily Unemployed	105, 106
Head Start:	
Objectives	90
Performance Standards	26, 144
Strengthening of	133
Health Professions	131
Immunization, Childhood	75, 103
JOBS/GAIN	121
Low Income Home Energy Assistance Program:	
Budget Reduction	19
Historical Data	94
Medicaid Provisions	153
Medicare:	
Program	63, 64
Report	21
Trust Funds	73
Trust Funds, Safeguarding	137
Minority Involvement	138
Nursing Home Regulations	27
Opening Statement	1, 6
Operation Restore Trust	154, 155
Outyear Projections:	
Discretionary Programs	17

Secretary of Health and Human Services—Continued

Outyear Projections—Continued	
National Institutes of Health	89
Performance Partnership	68
Personnel:	
Excepted	54, 55, 69
Job Classification	55
Staffing Reductions	115
Program Consolidation:	
ACF Program Consolidation	61
CDC Program Consolidation	59
HRSA Program Consolidation	58
SAMHSA Program Consolidation	60
Streamlining	56, 57, 65
Program Support Center	118
Public Health and Science, Office of	66, 114
Refugee Assistance	19
Research:	
Acquired Immunodeficiency Syndrome Funding	52, 70
Cancer Funding	71
Demonstration	110
Ryan White Programs	101
Substance Abuse and Mental Health Services Administration:	
Block Grant Funding	100
Surgeon General:	
Nomination	66
Qualifications	73
Role of	41
Teen Pregnancy:	
Prevention	39, 102, 132
Tobacco:	
American Stop Smoking Intervention Study (ASSIST)	42
ASSIST Contracts	48
Usage	42
Toll-Free Hotline	156
Waivers:	
Managed Care	123
Welfare Reform	126
Welfare Reform and Minimum Wage	128
Waste, Fraud and Abuse	24, 62, 69

Health Care Financing Administration 157**Balanced Budget Act:**

Choice of Health Plans	184, 185, 197
Home Health Proposal	169–170
Medicaid	167, 175, 176, 198
Medicare	176, 190, 198, 203, 204
Negotiations	168, 169, 176, 177, 180–185

Clinical Laboratory Improvement Amendments:

Alternate Quality Assessment Survey (AQAS)	304
Authorizing Legislation	300

Budget:

By Object	355–356
Estimate Rationale	303
Facility Inspections	302, 319

Health Care Financing Administration—Continued**Clinical Laboratory Improvement Amendments—Continued**

Methods of Correction	303
User Fees.....	302, 304
Collaboration Between HCFA and AHCPR	200
Federal Administrative Costs:	
Authorizing Legislation	313
Beneficiary Services.....	316, 325
Electronic Information Support.....	227, 317
Market Research	317
Payments to States	324
Program Integrity and Management	321
Provider and Beneficiary Outreach	317
Budget:	
Account Summary	313
Historical Table	330
Rationale	220, 314
Claims Payment	315
FTE	225, 360, 361
Partnership with States	328, 329
Positions By Grade	362
Quality Assurance	319, 326, 327
Significant Items.....	377, 384-386
Foundation for Accountability (FAact)	200
HCFA On-Line.....	164, 224, 225, 316, 317, 318

Health Care Quality Improvement Program 165, 199, 226, 227, 319, 320

Health Care Trust Funds, Payments to:

Appropriation Language.....	255
Authorizing Legislation	343
Budget:	
Appropriations History Table	344
By Activity.....	257, 345
By Object	342
For Obligation	258
Summary of Changes	259
Increase over FY 1996	186
Health Plan Employer Data and Information Set (HEDIS)	199
Health System Performance:	
Beneficiary Health Status and/or Risk	308
Managed Care Access	308
Medicare Current Beneficiary Survey	308
Vulnerable Populations, Meeting Needs of	310
HMO Loan and Guarantee Fund:	
Amounts Available for Obligation	372
Appropriations Language	369
General Statement	371
Language Analysis	370
Information Counseling and Assistance Grants.....	191, 311
Long-Term Care Initiative	225, 319
Managed Care:	
Access to Quality Care	196, 197, 229
Enrollment	164, 196, 197
Growing Numbers Served	159
Historical Data	368

Health Care Financing Administration —Continued**Managed Care—Continued**

Managed Care Quality Improvement Program	200
Medicaid	239
Patient Outcomes	199

Medicaid:

Appropriations Language	235
Authorizing Legislation	238, 334
Beneficiary Services	250

Budget:

Amounts Available for Obligation	338
Appropriations History Table	335
By Activity	238, 336
By Object	337
Rationale	250
Summary of Changes	331

Components, Coordination of	240, 324
-----------------------------------	----------

Disproportionate Share Hospital (DSH) Payments	175
--	-----

Fraud Control Units	251
---------------------------	-----

GeoAccess	249
-----------------	-----

Growth:

Blind and Disabled Population	246
By Eligibility	245
Outlays	160, 244
Program Spending	245
Recipients	158, 160, 222, 223, 244

Language Analysis	236, 237
-------------------------	----------

Medstat Contract	249
------------------------	-----

Payments by Type of Service	339
-----------------------------------	-----

Payment policy (NH and LA)	176
----------------------------------	-----

Policy Development	240
--------------------------	-----

Premium Payments	242
------------------------	-----

Proposals Being Reviewed:

Alabama	248
Georgia	248
Illinois	248
Kansas	248
Louisiana	248
Missouri	248
New Hampshire	248
New York	248
Texas	248
Utah	248

Proposed Legislation	198, 251
----------------------------	----------

Review (Waiver)	165, 175, 240, 328
-----------------------	--------------------

Section 1115 Statewide Waivers:

Coverage Under	165, 229, 248, 307, 328
Delaware	248
Florida	248
Hawaii	248
Innovative Approaches	248
Kentucky	248
Massachusetts	248
Minnesota	248
Ohio	202, 248

Health Care Financing Administration —Continued**Medicaid—Continued****Section 1115 Statewide Waivers—Continued**

Oklahoma	248
Oregon	248
Rhode Island	248
Tennessee	248
Vermont	248

Section 1915(b) Waivers	196
-------------------------------	-----

Service Growth	241
----------------------	-----

State Estimates	340-341
-----------------------	---------

Survey and Certification	251
--------------------------------	-----

Title XIX	238
-----------------	-----

Tracking (Waiver)	240
-------------------------	-----

Medical Effectiveness	321, 322
-----------------------------	----------

Medicare:**Demonstrations (See Research, Demonstrations and Evaluation)**

Durable Medical Equipment (DME)	322
---------------------------------------	-----

End-Stage Renal Disease	310, 322
-------------------------------	----------

Flu Shots	226
-----------------	-----

Growth in Beneficiaries and Expenditures	157, 160, 222, 223
--	--------------------

Medicare Handbook	164, 172, 24, 225, 317
-------------------------	------------------------

Medical Savings Accounts	176, 203, 204
--------------------------------	---------------

Organ Procurement Organizations	192-195, 204, 205
---------------------------------------	-------------------

Peer Review Organizations	226, 227, 320
---------------------------------	---------------

Proposed Legislation	169, 170, 176, 190, 197, 198, 204
----------------------------	-----------------------------------

SMI Premium Estimates	186, 198, 346
-----------------------------	---------------

Tax on OASDI Benefits	204
-----------------------------	-----

Trust Fund Solvency	166, 167, 168, 173, 177, 198, 201
---------------------------	-----------------------------------

Trustees Report	177, 178
-----------------------	----------

Medicare Current Beneficiary Survey (MCES)	192, 308
--	----------

Medicare Contractors	270
----------------------------	-----

Administrative:

Costs	272
-------------	-----

Simplification	279
----------------------	-----

Authorizing Legislation	270
-------------------------------	-----

Beneficiary and Provider Services	273, 279, 316
---	---------------

Appeals	284
---------------	-----

Communications	285
----------------------	-----

Education and Training	285
------------------------------	-----

Budget:

Rationale	274
-----------------	-----

Claims:

Billing/Claims Payment	281, 315
------------------------------	----------

Processing	187, 281
------------------	----------

Reimbursement	282
---------------------	-----

Commercial Software	188, 189
---------------------------	----------

Customer Service	272
------------------------	-----

Expenditures, Control of	188, 272
--------------------------------	----------

Language Analysis	267
-------------------------	-----

Legislation	278
-------------------	-----

Medicare Secondary Payments	187, 323
-----------------------------------	----------

Participating Physician and Supplier Rates	285
--	-----

Payment Safeguards	163, 187, 276, 322, 323
--------------------------	-------------------------

Productivity Investments	278
--------------------------------	-----

Health Care Financing Administration —Continued**Medicare Contractors—Continued**

Provider Identification	280
Providers	363–366
Significant Items	374, 375, 381–384
Support Managed Care	273
Transitions	279
Medicare Transactions System	159, 162, 163, 186, 223, 228, 271, 278
National Governors' Association	167
Opening Statement	157
Organizational Chart	217
Program Integrity	163, 228, 270, 321
Medicare Benefit Integrity System (MBIS)	159, 163
Operation Restore Trust	163, 174, 175, 224, 321, 323
Stewardship of Trust Funds	162, 322
Program Management:	
Appropriation Language	266
Authorizing Legislation	350
Beneficiary Support Network	161, 221, 222
Budget:	
Account Summary	352
Administrative Cost Table	359
Amounts Available for Obligation	347
Appropriations History Table	351
By Activity	349
By Object	353, 354, 357, 358
Summary of Changes	232, 348
Growth Rates	158
Language Analysis	267
Percentage of Total Spending	158, 159, 161, 162, 219, 220, 313
Proposed Legislation	373
Research, Demonstrations and Evaluation:	
Accomplishments	306, 322
Authorizing Legislation	305
Budget:	
Account Summary	305
Rationale	192
Congressional Mandates	311
Demonstrations:	
Centers of Excellence	309
Competitive Bidding	309
Competitive Pricing	309
Coronary Bypass Graft Surgery	306
Medicare Choices	165, 229, 309, 310
Subvention with Department of Defense (DoD)	171, 172
Telemedicine	164, 229, 310
Funding Summary	311
Obligations by Program Areas	312
Significant Items	374, 378–381
Strategic Plan:	
Goals	225–229
Mission	224
Vision	224
Survey and Certification:	
Authorizing Legislation	286

Health Care Financing Administration —Continued**Survey and Certification—Continued****Budget:**

By Activity 286

Rationale 190, 293

Constituents Awaiting Surveys..... 189, 190, 201, 223

Enforcement:

Health 288

Safety Standards 288

Growth of Facilities 287

Home Health Agency Surveys 189

Legislative Proposals 190

Nursing Home Inspections..... 178, 179, 226

Regulations Defining "Harm" 179, 180

Redesign Survey Process 297

Significant Items..... 375-377

Survey Coverage 190, 292, 293

Terminations 367

Unit Cost Methodology, including Variations 191, 295

Total Funding..... 218, 231

Witnesses, Introduction of 157

Administration for Children and Families 387

Overview 387

Administrative Costs 429

Child Abuse 460, 492

Child Care and Development Block Grant 434, 479, 486

Child Care/Early Head Start 415

Child Care/Infant Care 490

Child Care/Welfare Reform 432

Child Welfare Budget Initiative 482

Child Welfare, Use of Funds 460

Children, State of 475

Community-Based Resource Centers 428, 483

Community Services Block Grant 426

Congressional Justification 493

Coordination of Federal Programs 414

Developmental Disabilities Programs 421

Emergency Assistance/Juvenile Justice 408, 467

Lake County 410

Family Preservation and Support 462

Family Violence 427

Head Start:

Carryover Balances 401

Charitable Contributions 400

Children Served 473

Early Head Start Initiative 481

Evaluations 399

Grantees:

Canceled 412

Terminated 398

Increases, Uses of 480

Non-Federal Support 401

Performance Measurements 399, 412

Process Requirements 413

Administration for Children and Families—Continued

Head Start—Continued	
Profile	478
Quality Control	474
Research	413
Teacher Education Requirements	400
JOBS	468
LIHEAP	
Administrative Costs	446
Average Resources	444
Carryover	438
Constant Dollar Value of Benefits	402
FY 1996 Funding, Adequacy of	489
Impact of Other Resources	437
Leveraging	454
REACH	458
Recipients	436, 476
Statistical Tables	441
Trends in Consumption, Expenditures, and Burden	448
Opening Statement	392
Refugee Assistance and Resettlement.....	424, 459
Responsible Fatherhood	472
Social Services Block Grant	426, 464
Social Services Research	484
Teenage Pregnancy Initiative	417, 423, 476
Waivers:	
AFDC/Welfare	411, 471
Wisconsin	419
Witnesses	387
Administration on Aging	891
Administrative Costs	918
Aging Network	892
Budget Estimates, Justification of.....	929-989
Bottoms-Up Planning	898
Consolidation	893, 899
Elder Rights	893
Funding Justification	926
Home and Community-Based Services	892
Introduction of Witnesses	891
Medicare and Medicaid	923
Number of Seniors:	
Demographics of Elderly	926
Increasing Numbers	922
Nutrition:	
Services	900
Programs	910
Meal for the Elderly	920
Program Funding	927
Ombudsman	906
Opening Statement	891, 895
Priorities for Aging Programs	903
Reauthorization.....	898, 902
Seniors' Concerns	924
Social Service Block Grant	914

	Page
Administration on Aging—Continued	
State of Florida	899
State of the Elderly	919
Targeting	891
Training, Research and Demonstration:	
Research and Demonstration.....	893, 914
Discretionary Activities	916
Witnesses	891
Work Opportunities	922

BOSTON PUBLIC LIBRARY



3 9999 05570 731 7

ISBN 0-16-052784-8



9 780160 527845

90000



